the Journal MICHIGAN STATE MEDICAL SOCIETY

AUGUST 1960 VOLUME 59 NUMBER 8



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Kalamazoo State Hospital



Southwestern Michigan Tuberculosis Sanatorium

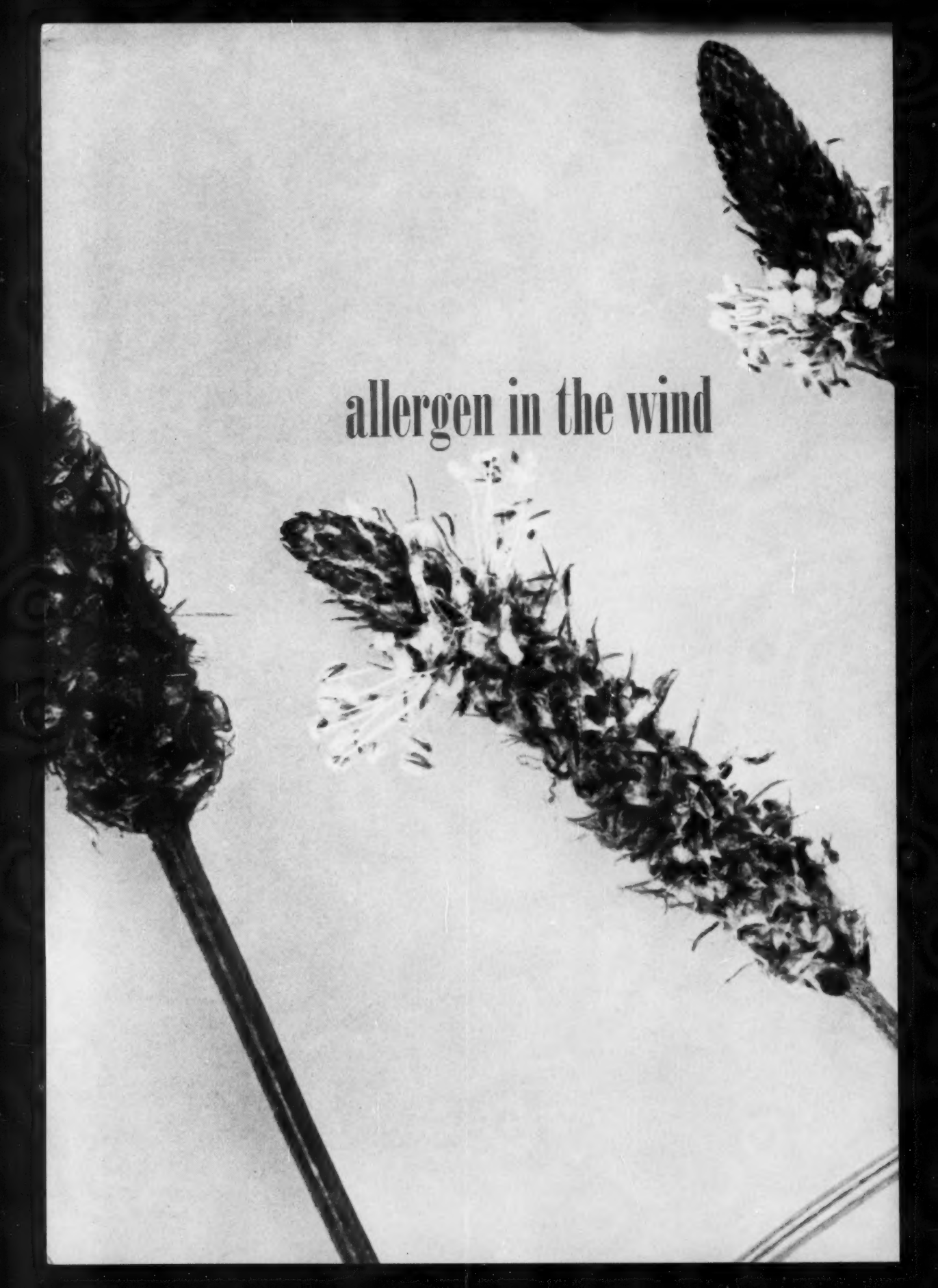


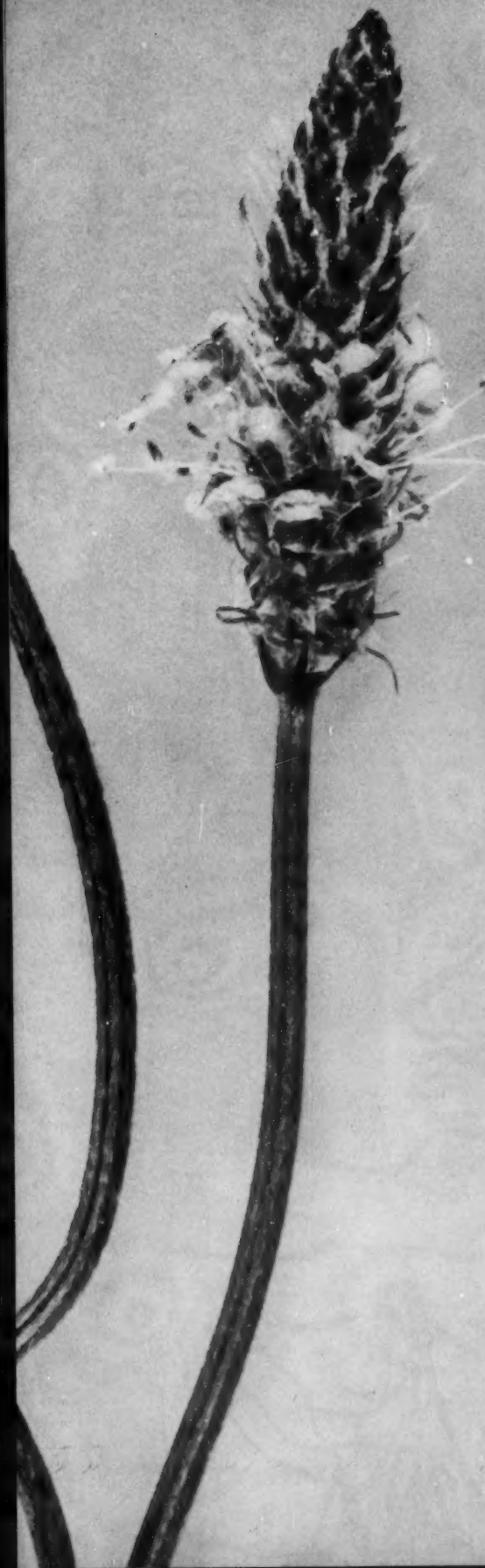
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August, 1960

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All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 2642 University Avenue, Saint Paul 14, Minnesota, or 606 Townsend Street, Lansing 15, Michigan. Telephone IVanhoe 2-1158.

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THE COVER

Once a year, a number of THE JOURNAL is dedicated to a county society and this number salutes the Kalamazoo Academy of Medicine. Interested county societies are invited to request such an arrangement.

IN THIS ISSUE

STATE SOCIETY SECTION 1161

President's Page 1160
MSMS Council Reports Progress 1161
Highlights of MSMS Council Meeting, June 22, 1960 1162
AMA Would Help Near-needy Aged 1166
The Ninety-fifth Annual Session—Information 1241

PUBLIC RELATIONS 1179

UPI Correspondent Lauds Work of Flint Doctors' Committee 1179
Saginaw Doctors Obtain Ambulance Licensing 1179

SOCIO ECONOMICS 1183

Researchers Find "Spectacular" Growth in Health Insurance 1183
Mortgage Aid to Health 1183

CLINICAL 1191

Right Heart Catheterization—*H. E. DePree, M.D., F.A.C.P.* 1191
The Treatment of Acute Volkmann's Ischemia—*J. L. Kihm, M.D., J. Hammer, M.D., R. E. Delong, M.D.,* and *R. L. Johnston, D.V.M.* 1195
Staphylococcus Enterocolitis—*Robert H. Hume, M.D.* 1200
The Diagnosis and Treatment of Subphrenic Abscess—*G. Allen Rogers, M.D.,* and *A. J. Neerken, M.D.* 1204
Acute Erythrophagocytic Hemolytic Anemia—*Paul S. Rutherford, M.D.* 1209
Poloxalkol in the Treatment of Constipation in Children—*James A. Dugger, M.D.* 1211
Perforated Peptic Ulcer in the Elderly Patient—*Franklin H. Cox, M.D.,* and *Ulrich Moeser, M.D.* 1213
Periodic Fever in Private Practice—*William D. Harrelson, M.D.* 1215
An Existential Approach to the Psychiatric Interview—*W. R. Slenger, M.D.* 1219
Ludwig's Angina with Associated Acute Glomerulonephritis—*Don G. Davis, M.D.,* and *Robert B. Burrell, M.D.* 1223
The Office and Out-patient Treatment of Leukemia—*Robert B. Burrell, M.D., August F. Fath, M.D.,* and *Paul S. Rutherford, M.D.* 1227
Surgical Significance of Subarachnoid Hemorrhage—*Preston S. Weadon, M.D.* 1230
Nursing Goals in a Psychiatric Unit Within a General Hospital—*Sister Marie George, S.S.J., R.N., B.S.* and *William A. Scott, M.D.* 1234

EDITORIAL 1237

Guest Editorial—Historical High-Spots of the Kalamazoo Academy of Medicine 1237
MMS Requested Rate Increase Again Reduced 1239
Use, Not Abuse 1240
Medical Expenditures 1240

ANCILLARY 1269

Dates Set for Michigan Conference on Aging 1269

NATIONAL AND WORLD 1273

Asks States to Advise on Elderly Care 1273
Urge Youths Enter Mental Health Careers 1273

NEWS BRIEFS 1285

Selected for Who's Who 1285

MISCELLANEOUS

Obstetrical Brevets 1266
Michigan Department of Health 1278
Pathology Comment 1280
Editorial Comment 1282
In Memoriam 1291
Communications 1292
Michigan Authors 1293
The Doctor's Library 1295



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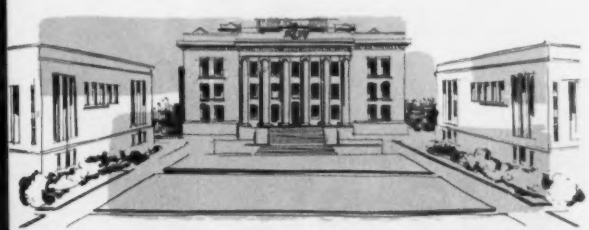
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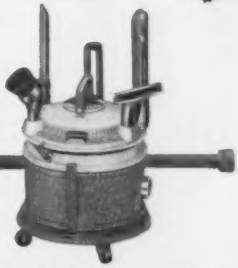
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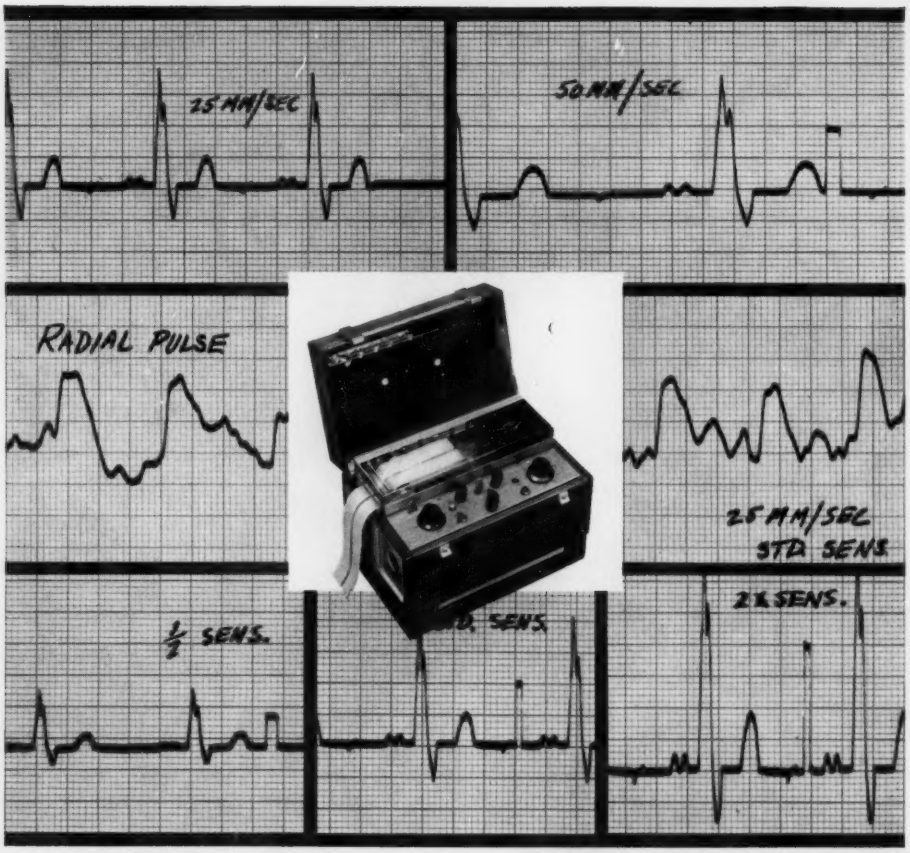
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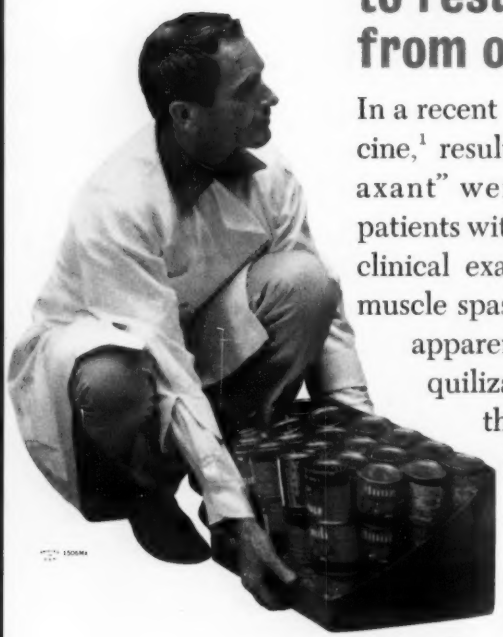
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"Porters' syndrome"*	21	5	1	1	28
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Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
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*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

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1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

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President's Page

REALISM VERSUS PESSIMISM



Milton A. Darling

President

Michigan State Medical Society

Where does realism leave off and pessimism begin?

We have heard the comment among doctors:

"Why fight the Forand-type legislative proposals this year—they'll pass next year even if we stop them today?"

"Let's just continue to practice good medicine and leave politics to the politicians."

Is this being realistic or pessimistic?

Frankly, I think these statements are not only pessimistic, I am confident they are based upon a lack of knowledge. From the findings of any number of studies we believe the following to be true:

1. That a great majority of the public doesn't want socialized medicine.
2. That socialized medicine will not be established in the early future by action of Congress.
3. That we, as doctors, have maintained a freedom to practice that is unequaled by any other profession.

It seems to be equally factual that we are in a never-ending fight to *maintain* our privileges to practice medicine free from unnecessary and unwanted governmental controls.

I think the priveleges of professional practice are worth the time we spend in fighting for them. They are worth more than that, in fact, because our continued success means our patients—which *en toto* are the public—will continue to get the highest quality of medical care!

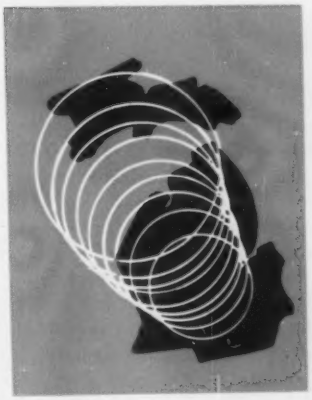
Let us be realistic. Let us recognize what has to be done—and do it. To me this means two things:

1. The dedicated practice of an ever-improving quality of medicine at fair fees by all doctors of medicine.
2. Active participation by them and their ancillaries in the current "Campaign for Freedom"— and like activity in the future.

The former we are pledged to do; the latter is our inescapable duty both as doctors and as citizens.

Let's do our job!

MSMS Council Reports Progress



The Council of the Michigan State Medical Society at its meeting July 14-15 approved the Annual Report of The Council. The Report appears in full in this number of THE JOURNAL, beginning on page 1254.

Following is a digest of that Annual Report, briefing only some of the major progress during 1959-60:

1. The singular progress of MSMS is most apparent when we look at the scientific side of the ledger. MSMS, its active components, and its good JOURNAL, all are doing an outstanding job keeping Michigan doctors "up-to-date scientifically."

2. The Presidents' Program will be presented in detail to the 1960 House of Delegates by President-Elect Kenneth H. Johnson, M.D. The proposed Presidents' Program is a five-year project that will join Medicine with all segments of the public primarily concerned with health, working as partners in a single-objective program designed to improve the health of the people. The individual doctor is asked to do the following:

(a) Promote this concept: five more good years can be added to the working life of the people. This will be accomplished mainly by saving lives and increasing the health of younger people (rather than merely extending years of the aged.)

(b) Develop specific programs on a *campaign* basis as: (1) public health campaign; (2) safety campaign; and (3) personal health appraisal.

All these efforts are to be under county medical society leadership, with necessary financial support from any and all sources to make the Program successful.

3. The Council invites the attention of every member to the Aging Program conceived and endorsed by Michigan's medical profession. The 10 MSMS objectives should be studied carefully and in detail. They represent the program of Michigan's M.D.'s in solving the health problems of the aged.

This important medical viewpoint must be presented to all the people and be the basis for our representations at the Michigan and the 1961 White House Conferences on Aging. Remember that politicians are trying to capitalize on the plight of some of the country's oldsters, trying to enforce upon them a regimented socialized scheme of compulsory health insurance in exchange for their votes in November. It behoves every M.D. in Michigan to bring the facts and the doctors' sensible program to the attention of all voters between new and Election Day. Only the individual practitioner can make effective the doctors' well-conceived campaign to solve this imminent problem.

4. The Michigan State Medical Society is a growing organization, best exemplified by its membership figures: an increase of 3,250 members in twenty-five years—from 3,410 in June 1935 to 6,660 members at the end of June this year.

5. A look at the Society's finances shows that for the first seven

(Continued on Page 1164)

HIGHLIGHTS of MSMS Council Meeting

Meeting of June 22, 1960

- Financial Report to May 30, 1960 (first half of Society's fiscal year) was presented by Finance Committee Chairman O. B. McGillicuddy, M.D., who reviewed the consolidated balance sheet which showed that expenditures were well within budgetary estimates for the first six months. The Chairman also presented a chart showing the growth of MSMS income and expense during the years 1951-59 which indicated that MSMS expenditures had outpaced the Society's growth of income.
- Report of AMA delegates on the June 1960 meeting was presented by Chairman Wm. A. Hyland, M.D., and referred to JMSMS for publication.
- Report on MSMS representatives to Upper Peninsula Medical Society annual meeting of June 17-18 was presented and accepted with thanks.
- Report of meeting of Advisory Committee to the Executive Director included résumé of activities of the staff since the April 13 meeting of this Committee: the daily staff meetings continued not only to bring closer communication to the personnel but eliminated expense, overlapping and duplication. Council Chairman H. J. Meier, M.D., commended the executive office staff on its efficiency, especially in developing crash programs (such as preparation of two important briefs presented at Michigan Insurance Commissioner's Hearings on Blue Shield's request for rate increase).
- Chairman Meier reported in detail on the testimony presented by MSMS representatives at the Insurance Commissioner's Hearings in Detroit on May 24 and in Grand Rapids on May 27; he also distributed copies of press clippings of the excellent news stories which had been carried by daily newspapers throughout the State, based on MSMS releases.
- The Council recommended that part of the last Session of the House of Delegates be called a "General Meeting" of the Society at which time the President and other officers of MSMS would be inducted into office. This change would comply with the Bylaws (Chapter 8, Section 1) and would save considerable time on the part of members during the Annual Session. The Officers Night ceremonies (usually held Wednesdays) would thus be moved up to Tuesday evening.
- The Council Chairman invited all Councilors to hold Councilor Conferences in their Districts immediately after the Mid-Summer Session of The Council (July 16) and before the MSMS Annual Session convenes in Detroit (September 25), in order to share information with Delegates, Alternate Delegates and component society officers on MSMS activities and on matters that may be considered by the 1960 House of Delegates.
- Mrs. W. G. Mackersie of Detroit, the new President of the Woman's Auxiliary to the American Medical Association, was recognized by a resolution of The Council, which also suggested that additional recognition be given to this lady, the first from Michigan to gain this high honor, at the 1960 House of Delegates Session.
- A copy of the Michigan State Plan for Hospital and Medical Facility Construction for the year 1960-61, as drafted by the Michigan Department of Health, was considered by The Council, and was received with thanks to J. R. Homminga, Chief of the Hospital Survey and Construction Section of the Department.
- Matters of mutual interest were discussed with Michigan Health Commissioner A. E. Heustis, M.D.
- Resignation of C. N. Hoyt, M.D., of Port Huron, Councilor of the Seventh District, to take effect September 25, was accepted with extreme regret; a vote of thanks to Doctor Hoyt for his service to MSMS and to the medical profession of Michigan was placed upon The Council's minutes.
- Report on Annual Session of Illinois State Medical Society was presented by President Milton A. Darling, M.D. and Secretary D. Bruce Wiley, M.D., who represented MSMS at this convention.
- Progress Report on the new MSMS headquarters building was presented by President Elect K. H. Johnson, M.D., on behalf of the Big Look Committee. The new completion date has been set by the Architect as December 1.
- The MSMS Committees for 1960-61 were presented by President Elect K. H. Johnson, M.D., and confirmed by The Council.
- Wm. Bromme, M.D., was appointed Chairman of the 1961 Conference for Residents-Interns-Senior Medical Students, to be held coincident with the Michigan Clinical Institute in Detroit.
- Legal Counsel's Report included opinion on propriety of a doctor or hospital divulging information regarding statements; and also further elucidation on dangers in volunteering for emergency service

(Continued on Page 1164)

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IN ELDERLY PATIENTS well tolerated by debilitated patients	"... seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.
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IN HYPEREMOTIVE ADULTS does not impair mental acuity	"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

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MSMS Council Reports Progress

(Continued from Page 1161)

months of 1960, MSMS is living well within its annual budget. Roughly 97% of its estimated income already has been received; expenses at this point of the year are 58% of general fund estimates for twelve months.

6. The membership should note that, even though demands on MSMS's legislative activity were as great as ever in 1960, the lawmakers of Michigan adopted no measures inimical to the best health interests of the people. Sincere thanks go to our Michigan Legislators.

It is not necessary to point out that the activities of those persons and groups advocating socialized medicine on the national scene have been stepped up during the past year; the advocacy and pressure for Forand-type legislation is the most obvious evidence. Those opposing Medicine's viewpoint are doing so far more openly and publicly than heretofore; now, they have no fear of being labeled "socialistic." The medical profession must face challenge to save the private practice of medicine. A *unified* front and a vigorous campaign must be presented *now*, if Medicine's progress of the past is to be maintained this year and in the future.

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Highlights of MSMS Council Meeting

(Continued from page 1162)

(to be published in JMSMS to amplify original opinion).

- Public Relations Counsel's Report included information on Ciba TV program (26 weeks' series entitled "This Week in Medicine"); report on physician's career guide; progress report on Michigan Association of the Professions; and recent public presentations by members of the staff.

- Appointments: (a) Otto J. Preston, M.D., Flint, as representative to AMA Conference of Chairmen of State Medical Society Committees on Industrial Health, October 10; (b) MSMS representative to attend Annual Session of Woman's Auxiliary in September: President Elect K. H. Johnson, M.D., Lansing; (c) MSMS representatives to AMA Regional Meeting on Legislative Activities, August 12-13: L. A. Drolett, M.D. and H. W. Brenneman, Lansing; (d) Advisory to Committee on National Defense: Wm. H. Beierwaltes, M.D., Ann Arbor; (e) MSMS nomination to Michigan Hospital Service Advisory Committee: E. P. Griffin, Jr., M.D., Flint.

- Reports: (a) On meeting of MSMS representatives to Michigan Welfare League's Committee on Reimbursement to Visiting Nurses: Wm. M. LeFevre, M.D., Muskegon, reported that the Committee recommend that the Visiting Nurse Association be utilized by social welfare departments and that they be paid from public assistance funds where available.

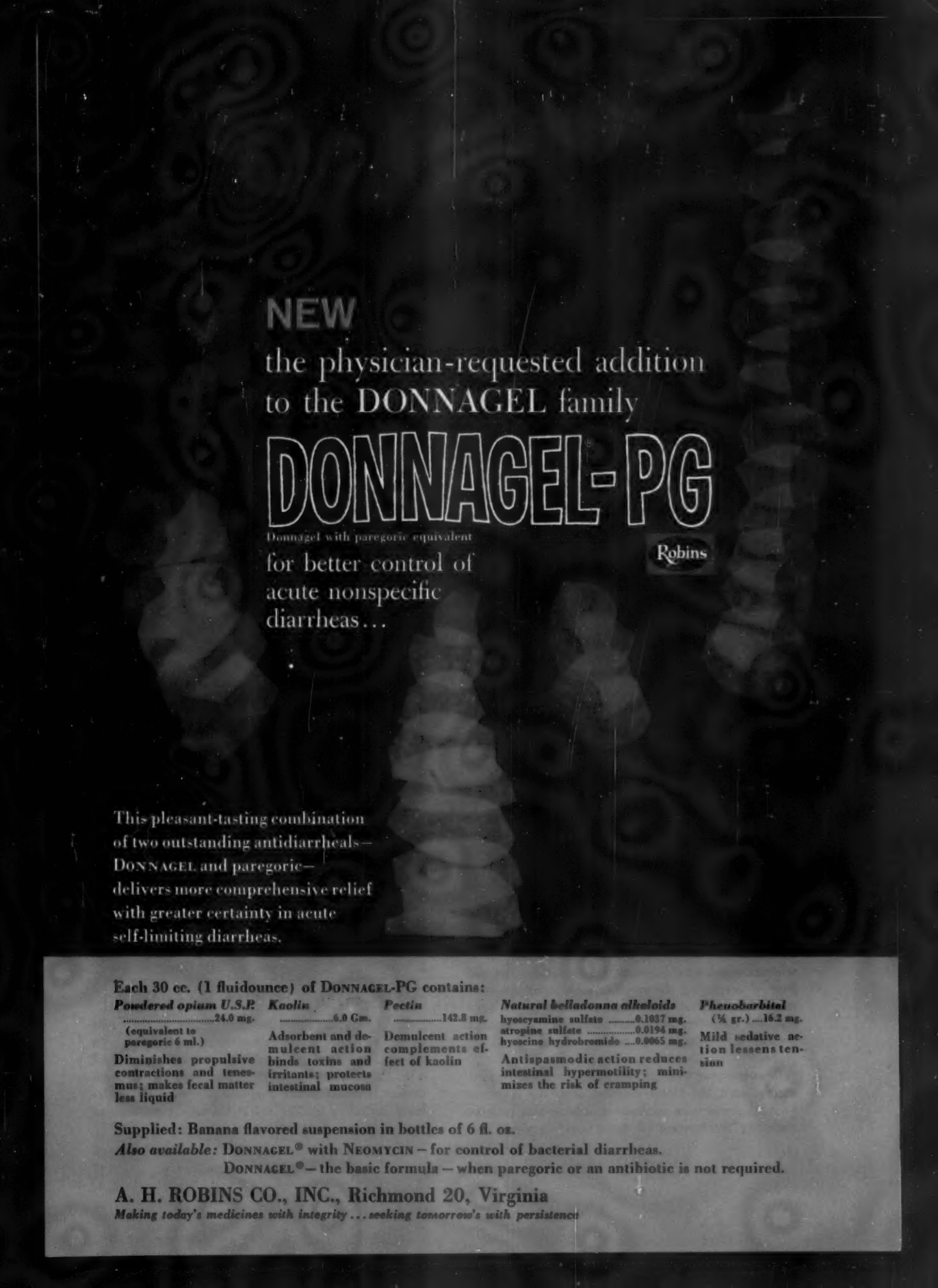
  (b) Report of Stephen Wilson of Wayne State University College of Pharmacy, who represented MSMS at 1960 meeting of the United States Pharmacopoeial Convention, was received with thanks and referred to JMSMS for publication.

  (c) Report of L. W. Gardner, M.D., Detroit, who as MSMS representative, covered annual meeting of Board of Directors of North Central District Blood Bank Clearing House, Chicago, June 11, was received as information, with thanks.

Health Benefits Program

At least 1,450,000 employes have enrolled in the Federal employes health benefits program, according to preliminary and incomplete registration figures received from thirty-five of the thirty-eight carriers of participating health benefit plans, the Civil Service Commission has announced. The new program went into effect early this month.

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AMA Would Help Near-Needy Aged

The American Medical Association House of Delegates, at its 109th annual meeting in Miami Beach, supported a plan of voluntary grants-in-aid financed by Federal funds to help provide health care for the "near-needy" aged.

Other major subjects involved in policy actions were pharmaceutical issues, occupational health programs and relations with allied health groups.

Leonard W. Larson, M.D., of Bismarck, N. D., former chairman of the AMA Board of Trustees and of the AMA Commission on Medical Care Plans, was named president-elect by unanimous vote. Dr. Larson will succeed E. Vincent Askey, M.D., of Los Angeles, at the Association's annual meeting in June, 1961, at New York City.

Health Care for the Aged

After considering a variety of reports, resolutions and comments on the subject of health care for the aged, the House of Delegates adopted the following statements as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

The House also urged the Board of Trustees "to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health service and facilities needed by the aged, and that thereafter the American Medical Association present its findings and positive principles to the people."

In connection with an educational program regarding the aged, the House declared that "the American Medical Association increase its educational program regarding employment of those over sixty-five, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

The House also gave wholehearted approval that state medical societies be urged to take an active part in state conferences and the White House Conference on Aging.

Pharmaceutical Issues

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient.

The House also directed the Board of Trustees to request the Council on Drugs and other appropriate Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June, 1961."

Occupational Health Programs

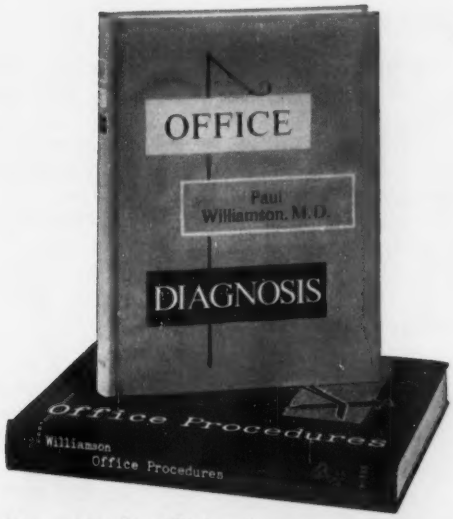
The House approved a revised statement on the "Scope, Objectives and Functions of Occupational Health Programs," which was originally adopted in June, 1957. The new statement contains no fundamental alterations in AMA policy or ethical relationships, but it adds some important new material, for example, the House now urges greater emphasis on the preventative and health maintenance concepts of occupational health programs.

The House also accepted a suggestion that the AMA Council on Occupational Health undertake a project to study and encourage the employment of the physically handicapped.

Allied Health Groups

The House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services and commended it as "a monumental work." The report covers the present situation, future implications and recommendations, including guiding principles and approaches to

(Continued on Page 1168)



2 Companion Volumes
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Office Diagnosis

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The authors have brought this new edition fully up-to-date. The chapter on *Bookkeeping* is expanded with many new illustrations on the "write-it-once" bookkeeping system, etc. The chapter on *Instruments* is now much more detailed and clearly illustrated. Much new help is added on sterilization.

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Allied Health Groups

(Continued from Page 1166)

activate physician leadership. The House strongly recommended that AMA activity in this vitally important area be continued and it approved the appointment of a Board of Trustees committee to carry on the work.

The House took action involving relations between the medical profession and the National Foundation. It adopted a statement of policies for the guidance of state medical associations and recommended that they be adopted by all component medical societies. These policies cover such subjects as membership of medical advisory committees at the chapter level, the function of these committees, and basic principles concerning financial assistance for medical care, payment for physicians' services and physicians' responsibilities for constructive leadership in medical advisory activities.

Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House also:

Strongly reaffirmed its support of the Blue Shield concept in voluntary health insurance and approved specific recommendations concerning AMA Blue Shield relationships;

Approved a contingent appointment of not more than six months for foreign medical school graduates who have been accepted for the September, 1960, qualification examination;

Agreed that the American Medical Association should sponsor a second National Congress on Prepaid Health Insurance;

Approved the establishment of a new "Scientific Achievement Award" to be given to a non-physician scientist on special occasions for outstanding work;

Approved the following schedule for future annual meetings: Atlantic City, 1963; San Francisco, 1964; and New York City, 1965;

Approved the objectives of the AMA Commission on the Cost of Medical Care;

Urged individual members of the Association to take a greater interest and more active part in public affairs on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the Social Security Act and recommended immediate action by all AMA members who agree with that position;

Urged reform of the federal tax structure so as to return to the states and their political subdivisions, their traditional revenue sources;

Asked state and county medical societies to make greater use of AMA recruitment materials in presenting medicine's story to the nation's high schools;

Requested the Board of Trustees to initiate a study of present policy regarding the required content and method of preparing hospital records;

Directed the Board of Trustees to develop group annuity and group disability insurance programs for Association members; and

Expressed grave concern over the indiscriminate use of contact lenses.

Addresses

Dr. Orr, in his final report to the House at the opening session, urged medical societies to "adopt" rural villages, cities and regions in underdeveloped parts of the world and to send them medical, clinical and hospital supplies.

Dr. Askey, in his inaugural address, urged intensified, accelerated effort in five areas—medical education, preparations for the White House Conference on Aging next January, health insurance and third party relationships, mental health, and membership relations.

Michigan M.D.'s Honored

W. A. Hyland, M.D., Grand Rapids, treasurer of MSMS, was elected a member of the executive committee of the Conference of Presidents and Other Officers of State Medical Associations, and was elected also chairman of the Constitution and Bylaws Council.

William Bromme, M.D., Detroit, member of The MSMS Council, was elected treasurer of the National Medical Veteran Society.

Arthur C. Curtis, M.D., Ann Arbor, chairman of the MSMS Committee on Syphilis, was chosen chairman of the section on dermatology of the AMA.

The Scientific Section

At the 109th Annual Session there were many from Michigan acting as Section officers, speakers of panels, discussants or presented papers contributing to the scientific Assembly. These are worthy of mention in addition to those who had official administrative duties. This list, all Doctors of Medicine unless otherwise specified, will mention the name and address, but no attempt to list the title of paper or presentation:

Richard A. Oberfield, Detroit; Renato C. Starrico, Detroit; Kimie Fukuyama and I. A. Bernstein, Ann Arbor; James E. Greer, Richard R. Menard, and Clarence S. Livingood, Detroit; William M. Tuttle, Detroit; William R. Eyler, Detroit; Stewart N. Nickel, Roy Frame and Jos. Bebin, Detroit; and Wallace W. Tourtellotte, Ann Arbor; Robert K. Nixon and William O'Rourke, Detroit; C. Donald Albers, Grand Rapids;

(Continued on Page 1170)

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The Scientific Section

(Continued from Page 1168)

Joseph H. Shaffer, Detroit; Frederick C. Swartz, Lansing; E. S. Gurdjian, Detroit; J. Reimer Wolter, Ann Arbor; Mathew Aloern, Harold F. Falls and Gilbert B. Lee, Ann Arbor; Joseph A. Johnston, Michael James Sweeney, Richard Brown, Gordon Manson and John Walker Maloney, Detroit; James W. Rae, Jr., Ann Arbor; Edwin M. Smith, Ann Arbor; Thaian Leucutia, Detroit; John K. Ormond, Pontiac; Marvin W. Woodruff, Richard L. Malvin, and Ian M. Thompson, Ann Arbor; Jack Lapides, Ann Arbor; A. Waite Bohne, Richard C. Urwiller, and Donald F. Armento, Detroit; Robert J. Priest, Detroit.

Scientific Exhibits: Philip C. Brockman, Grand Rapids high school student, a prosthetic tendon; John W. Sigler, Detroit; Joseph L. Flemming, Robert S. Knighton, and William C. Noshay, Detroit; Paul R. Winder, Richard M. Caplan, Walter D. Block, and Arthur C. Curtis, Ann Arbor; Conrad R. Lam, Rodman E. Taber, Edward Green, and Ellet Drake, Detroit; David J. Sandweiss, Marcus H. Sugerman, Richard Remington, Gilbert M. Berman, Jack A. Litwin and Alice Beecher, Ann Arbor and Detroit; Virgil N. Slee, G. Stanley Woodson, Lorenzo Roderiguez-Feralta, Ann Arbor; J. Martin Miller, Melvin A. Block, Raymond Mellinger, Detroit; Jan Nyboer, Javid Jay, and Robert Davidson, Detroit; E. S. Gurdjian, W. G. Hardy, D. W. Lindner, M. Croll, S. J. Fiegel, J. E. Lofstrom, J. E. Webster, and J. L. Whelan, Detroit; J. F. Johnson and N. J. Furiosi, Detroit; Brenton M. Hamil, W. B. Eyler, J. W. Rebuck, G. A. LoGrippo, Detroit; William Umiker, Donald Korst, Ann Arbor; W. C. Schaefer, C. E. Rupe, R. E. Birk, and J. C. Sheracki, Detroit; Walter M. Whitehouse, Robert Rapp and Howard E. Fink, Jr., Ann Arbor; Irving Feller and Marion De Weese, Ann Arbor; Joseph L. Pomka, Brock E. Brush, R. O. Amtoni and R. B. Marshall, Detroit; John M. Sheldon, Narry A. Towsley, Park W. Willis III, George H. Lowrey, G. Thomas Flotte, and Samuel J. Behrman, Ann Arbor.

The last group listed, Drs. Sheldon, Towsley, Willis, Lowrey, Flotte and Behrman presented a most unusual and instructive exhibit designed to arouse and increase the interest of practicing physicians for continuing education. It illustrated the Michigan Plan for postgraduate medical education as implemented by the University of Michigan Medical Center, Wayne State University College of Medicine, Michigan State Medical Society, and the Michigan Department of Health. The postgraduate educational opportunities were graphically demonstrated in order to inform licensed physicians graduated from approved medical schools of the program.

16th Conference of Presidents and Other Officers

Back in 1945, on April 27 and 28, at the Wardell Hotel in Detroit, upon invitation of Andrew S. Brunk, M.D., president of the Michigan State Medical Society, the Presidents and Presidents-Elect of 17 state medical societies assembled as guests of the Michigan State Medical Society. So many items of common interest not then met by recognized groups were found that a permanent organization was provided. Annually the Presidents' Conference has presented outstanding and challenging programs.

The sixteenth Presidents' Conference in Miami lived up to precedent. Following talks by the President and the President-Elect came Mississippi's Governor, Ross Barnett, an attorney serving his first term. He said the states, not the Federal government, should take care of needy elderly persons' health care. A handful of "power mad and greedy politicians," he said, are pushing "socialized medicine" in an effort "to dictate our every action from Washington."

Paul M. Butler, National Chairman of the Democratic Party, predicted the Democratic Convention will endorse a political plank calling for approval of the controversial Forand Bill.

There was a scattering of "boos" when Butler told the audience that a Los Angeles official recently had testified that "the high cost of medical care is the most important reason for suicide among the aged."

Sen. Thruston B. Morton (R., Ky.), GOP National Chairman, asserted that his party is flatly opposed to any compulsory approach as embodied in the Forand measure. He said he believed the Republic convention will approve a voluntary program that could be worked out in conjunction with the states.

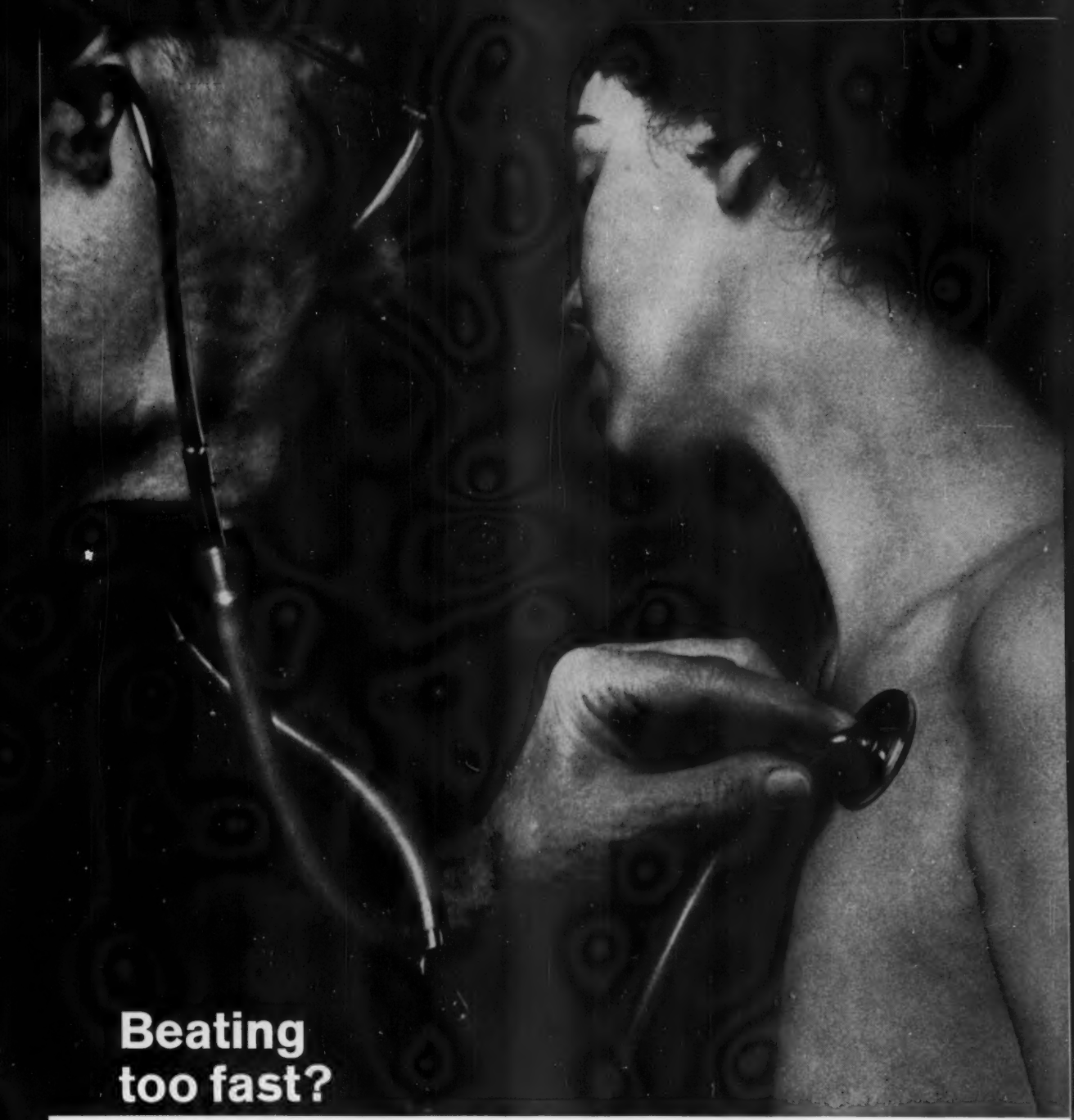
Honor Editor Haughey

Wilfrid Haughey, M.D., Battle Creek, was honored for having attended the past fifty meetings of the American Medical Association House of Delegates. He had served as Delegate at St. Louis in 1910, thus 1960 marks his 50th anniversary. The AMA has never given this recognition before.

The honoring resolution was adopted by a unanimous standing vote of the AMA delegates.

Doctor Haughey was attending this AMA meeting in his capacity as editor of THE JOURNAL. In past years, he had attended either as Secretary of MSMS, Michigan Delegate to the AMA or as editor.

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Mrs. Mackersie Urges More Active Citizenship

Doctors and their wives "must answer the call of courageous citizenship" to preserve and enhance American medicine's great heritage.

In her inaugural message at Miami Beach as the president of the Woman's Auxiliary to the American Medical Association, Mrs. William Mackersie, Detroit, stressed more active personal citizenship as a major goal for Auxiliary members during the year ahead. Other top priority projects outlined by Mrs. Mackersie include recruitment for health careers, positive legislative action and fund-raising for the nation's medical schools.



MRS. MACKERSIE

Mrs. Mackersie succeeds Mrs. Frank Gastineau, Indianapolis, Indiana. The new president-elect is Mrs. Harlan English, Danville, Illinois.

At Miami Beach, the Auxiliary presented a check for $170,230 to the American Medical Education Foundation.

For the first time, the "Ethel Gastineau Trophy" was awarded to the Woman's Auxiliary to the Tennessee State Medical Association for outstanding efforts on behalf of the AMEF.

AMEF awards of merit were presented to the auxiliaries of the following state medical societies: Hawaii, Alaska, Nevada, New Hampshire, Indiana, Tennessee, Wyoming, Arizona, Ohio and Alabama. The national Auxiliary, Mrs. Gastineau and Mrs. Karl F. Ritter, Lima, Ohio, also received merit awards.

The Auxiliary convention heard Edward L. Bortz, M.D., Philadelphia, former AMA president, say, "The time has come to draw up a blueprint on how to live to be 100 by taking advantage of the health information we have today." Louis M. Orr, M.D., then AMA president, urged members to a greater awareness of the need for medical knowledge, supplies and equipment by underdeveloped nations throughout the world.

Other business sessions were devoted to state and national reports, an outstanding film program, round table discussions and speeches by AMA staff personnel and medical leaders.

Heidenrich to Head UP Medical Society

John R. Heidenrich, M.D., Daggett, was elected president of the Upper Peninsula Medical Society at the closing business session of the annual convention June 17-18 in Ecanaba. George H. Hopson, M.D., of Menominee, was named secretary-treasurer.

With election of the two officers from Menominee County also came the convention for 1961, which will be held in Menominee next June.

The convention wound up Saturday night with a banquet and dance at the House of Ludington. Banquet speaker was Ann Landers, columnist of the *Chicago Sun-Times*.

Saturday morning's session heard lectures by Frank H. Mayfield, M.D., University of Cincinnati Medical School Department of Neurosurgery, on "The Management of Head Injuries"; Edward Stepan, M.D., of Chicago, on "Allergy Diseases in Children," and Richard L. Rapport, M.D., of Flint, on "The Fractured Rib—A Significant Injury."

Out-of-State Meetings

The 48th Annual Meeting of the Clinical Orthopaedic Society will be held in Milwaukee, October 20, 21 and 22, 1960. The headquarters will be the Schroeder Hotel, with clinical sessions being held in the Memorial Center on the Lake.

* * *

The University of Cincinnati reports there are still places available for the Postgraduate Course in Heart Disease, September 7-8-9-10, 1960. Write Johnson McGuire, M.D., College of Medicine, University of Cincinnati, Cincinnati 29, Ohio.

Michigan Medical Meetings and Clinic Days

September 9-11	Medical-Dental Seminar on Hypnosis	Detroit
September 25-30	Michigan State Medical Society. Annual Session	Detroit
September 27-29	Annual Meeting, Woman's Auxiliary to Michigan State Medical Society	Detroit
September 28-29	Annual Meeting, Michigan State Medical Assistants Society	Detroit
December 1-3	Western Surgical Association	Detroit



she calls it "nervous indigestion"

diagnosis: a wrought-up patient with a functional gastro-intestinal disorder compounded by inadequate digestion. **treatment:** reassurance first, then medication to relieve the gastric symptoms, calm the emotions, and enhance the digestive process. **prescription:** new Donnazyme—providing the multiple actions of widely accepted Donnatal® and Entozyme®—two tablets t.i.d., or as necessary.

Each Donnazyme tablet contains
—In the gastric-soluble outer layer: Hyoscyamine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital (1/8 gr.), 8.1 mg.; and Pepsin, N. F., 150 mg. **In the enteric-coated core:** Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

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DONNAZYME®

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Proven

in over five years of clinical use and
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Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
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- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient



Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

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meprobamate (Wallace)

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"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study*

(as reported in J.A.M.A., April 30, 1960)

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

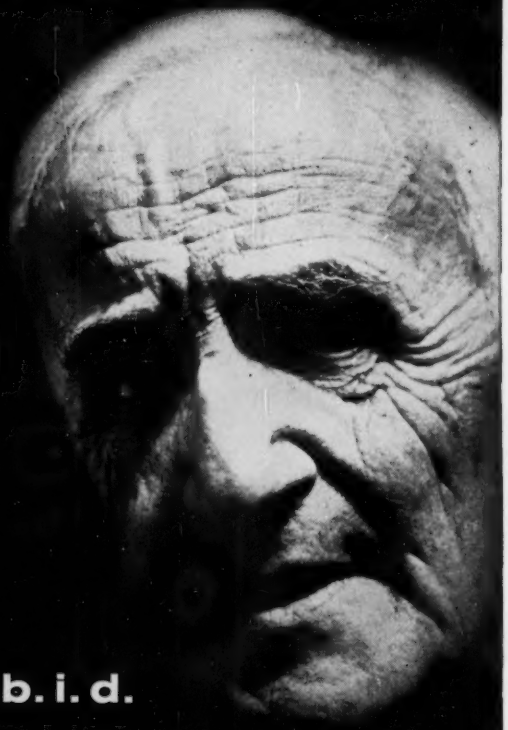
Literature and samples on request.

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IN SENILE CONFUSION . . .



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Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
  Pentylenetetrazol .....300 mg.
  Nicotinic Acid .....150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atherosclerotic psychosis.
- Supplied: Bottles of 42 Tablets (3 weeks' treatment)

* TEMPOTROL (Time Controlled Therapy)

COLUMBUS PHARMACAL COMPANY
Columbus 16, Ohio

UPI Correspondent Lauds Work Of Flint Doctors' Committee

Washington correspondent for United Press International, Louis Cassels, wrote a recent feature story on alcoholism based on the booklet, "A Happy Solution to the Problem of Alcoholism," published by the Genesee County Medical Society.

The story received national attention and Mr. Cassels praised the Flint doctors who prepared the booklet. He urged wider distribution of the material which emphasizes that alcoholism is a disease, and those who are stricken with it cannot simply "will it away."

* * *

Saginaw Doctors Succeed in Obtaining Ambulance Licensing for City

Spearheading a drive to regulate and license ambulances and attendants, the Saginaw County Medical Society was rewarded recently when the City Council passed a local ordinance based on recommendations of the Society's Trauma Committee.

The ordinance will license ambulances and attendants and incorporate training and equipment requirements. Each ambulance will be manned by two persons, a qualified attendant with first-aid training and a driver who may or may not be a licensed attendant. Equipment to be carried in each ambulance is specified in the ordinance.

An ambulance code was first suggested by the Saginaw doctors in March and was subject to growing controversy until May when a revised code was accepted by The Council without objection.

Detroit Doctor Selected Father of Year--- Is Bachelor!

A Detroit bachelor with some 8,000 "children" was named Father of the Year in June by the mothers and children he had delivered in forty years of practice as an obstetrician.

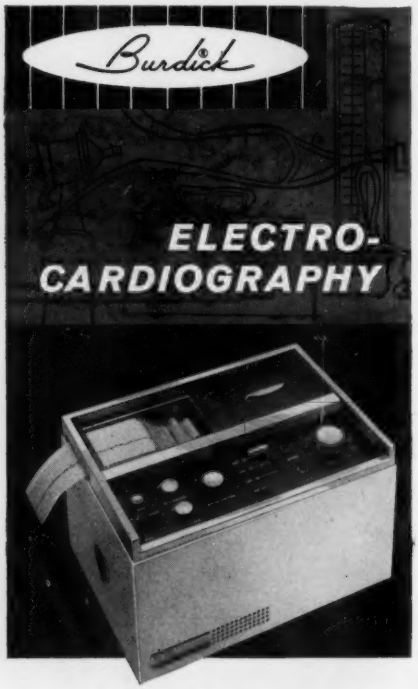
Owen C. Foster, M.D., was greeted by 500 men and women when he walked into the Grand Ballroom of the Sheraton-Cadillac Hotel presumably to have lunch with a friend who was in on the surprise. Nearly all those at the luncheon were women patients of Doctor Foster when they had their babies.

Sitting opposite Doctor Foster at the head table were 40 young people, each of whom he had brought into the world—one for every year he has practiced.

He was given presents and the key to the city by Detroit's Mayor Miriani.

Heads Senior Citizen Planning Unit

Clayton K. Stroup, M.D., Flint, has been named chairman of the



. . . an integral part of modern practice

Has the diagnostic equipment in your office kept pace with your own knowledge of new drugs, medicines and therapeutic technics? If not—call in your Burdick man!

He'll bring you up to date on the latest advances in electromedical instrumentation—as for example, the Burdick dual-speed electrocardiograph. Determine your net cost of new equipment, taking into consideration the income tax savings from annual depreciation allowances. This can make the purchase of new professional equipment far more attractive financially than you may have realized!

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community-planning committee for senior citizens, a unit of the Council of Social Agencies.

Doctor Stroup, chairman of the group's health subcommittee, is a past president of the Genesee County Medical Society.

The planning committee recently published findings and recommendations based on an extensive study of older persons in Flint.

New Radio Series Ready

The University of Michigan Broadcasting Service (WUOM) will initiate a 56-program series this fall on "Human Behavior; Social and Medical Research." Producer Glen Phillips traveled throughout the United States for six months interviewing leading educators, doctors, sociologists, and psychologists in the field of human behavior and medical research. Phillips has subdivided the series into four parts: "Medical Research," "Behavioral Science Research," "Aspects of Mental Health," and "The Challenge of the Aging."

One of the programs on "Aspects of Mental Health" includes the views of Paul Dudley White, Boston physician, on "Safeguards Against Mental Illness."

The series, produced by the U-M Broadcasting Service, will be released nationally by the NAEB.

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meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

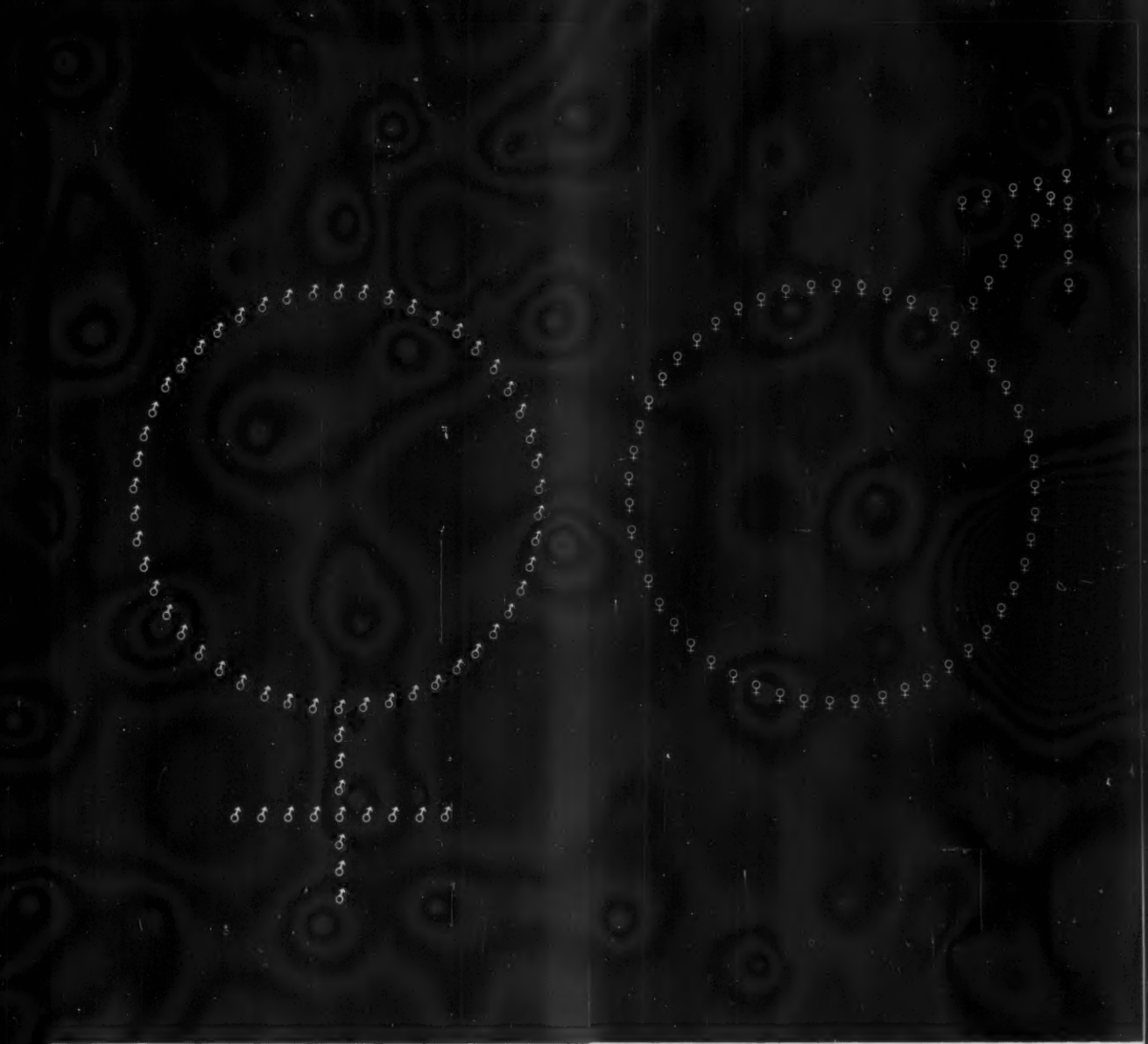
FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle



GONORRHEA IS ON THE MARCH AGAIN...

a new timetable for recovery:

only six capsules of TETREX can cure a male patient with gonorrhea in *just one day*•

Tetrex®

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THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

TETREX CAPSULES. 250 mg. Each capsule contains: TETREX (tetracycline phosphate complex equivalent to tetracycline HCl activity) – 250 mg.

DOSAGE: Gonorrhea in the male – Six capsules of TETREX in 3 divided doses, in one day.

• Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

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BRISTOL LABORATORIES,
SYRACUSE, NEW YORK

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy



As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

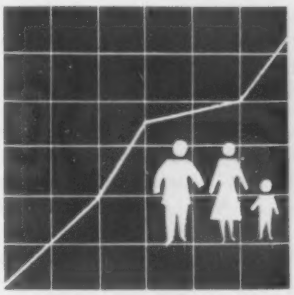
*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

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Squibb Quality—the Priceless Ingredient

Researchers Find "Spectacular" Growth in Health Insurance



Private health insurance in the United States is well on the way toward accomplishing what many experts in the field of social security stated on innumerable occasions was impossible, namely, near universal coverage of the whole population.

This is the principal finding of Rita R. Campbell and W. Glenn Campbell in a study, "Voluntary Health Insurance in the United States." Professor W. Glenn Campbell is director of the Hoover Institution on War, Revolution, and Peace at Stanford University and his wife has served as a staff economist on the House Ways and Means Committee.

* * *

MANY OF THE FINDINGS of this study are pertinent to the current controversy concerning a national health program for the aged. On the question as to whether the aged can afford to pay for their own health care, the authors conclude:

> "Based on the extensive evidence examined in this study, it seems clear that a substantial majority of today's aged can afford to pay for health insurance and that in the future the percentage will be even higher. Certainly the four million persons over 65 who are either employed or wives of employed persons can pay for their own health care. In addition, the almost universal coverage of OASDI, the continuing and rapid expansion of private pension plans, and the steadily increasing real national income are signs pointing to the future when the great majority of the retired aged will be, if they are not already, out of the category of those unable to pay for their own health care."

* * *

THE AUTHORS DESCRIBE the growth of private health insurance as "spectacular" and a "striking example of the unparalleled contributions that have been made to American life by voluntary and co-operative effort."

The authors find that the percentage of the nation's resources devoted to health is higher in the United States than in Great Britain—a country with governmental provision for medical care for all. They also point out that:

> "Experience with the British National Health Service clearly demonstrates that provision of health care by government does not solve the problem of "adequate" health care for all, as is so often claimed by proponents of compulsory health insurance."

* * *

ON THE HIGH cost of medical care, the authors state that "it is obvious that the rise in hospital costs is the important cause of concern."

The Campbell study was published by the American Enterprise Association of Washington, D. C.

Mortgage Aid to Health

"There's a tremendous need for more nursing homes run by physicians." And a good many physicians are apparently eager to help meet this need by building and operating their own nursing homes. That's the report from Frank C. Bateman, executive director of the American Nursing Home Association.

Previously, the few doctors who actually built nursing homes had

to rely on private financing. Money from Government agencies was usually available only for non-profit projects. But now a new Federal Housing Administration program makes mortgage insurance available for building privately owned nursing homes.

National Blue Shield Study Commission Established

A "Blue Shield Study Commission" has been established by the National Association of Blue Shield Plans to undertake a major study of the "differences of concept and coverage" among the nation's 75 Blue Shield Plans which "have resulted in different approaches to the problem of providing adequate protection to the public."

Donald Stubbs, M.D., chairman of the Board of the National Association, has pointed out that while the setting up of this Commission was directed by the Annual Conference of Blue Shield Plans in Los Angeles in April, its area of study and recomemndation is logically related to the action of the AMA House of Delegates in Miami on June 14, in reiterating AMA support of the Blue Shield Concept and providing for strengthened liaison between AMA and Blue Shield Plans.

"The job of this new Blue Shield Study Commission," said Dr. Stubbs, "is to identify and pinpoint the specific problems that must be solved and the needs that must be met within Blue Shield if it is to be able to extend the broadest possible medical prepayment protection, under medical auspices, to the greatest possible number of people, and thus make the maximum contribution both to the public welfare and to the free practice of medicine."

Chairman of the nine-man Commission is Dr. Henry S. Blake of Topeka, Kansas.

Three of its members are the AMA representatives on the Board of Directors of the National Blue Shield Association: Drs. David B. Allman of Atlantic City, N. J.; George M. Fister of Ogden, Utah; and Dwight H. Murray of Napa, Calif.; and other members are Drs. Carl R. Ackerman of New York City, Board Chairman of the New York City Blue Shield Plan; A. A. Morrison of Ventura, Calif.; Donald N. Sweeny, Jr., of Detroit, and also Lewis G. Hersey, Executive Director of the Medical Service Bureau (Blue Shield Plan) of the Utah State Medical Association; and Walter R. McBee, Executive Director of the Texas Blue Shield-Blue Cross Plans.

One of the newer Members of the Michigan Medical Service Board is included in this list, Dr. Sweeny. Mr. Hersey was formerly in Michigan.

Vermont Study Shows Most Oldsters Can Pay Medical Bills

More than 80 per cent of elderly Vermonters plan to pay their medical bills through Blue Shield, private insurance, savings or from current income.

This figure comes from a sample survey of the over-65 group made by the Committee on Aging of the Vermont State Medical Society. It emphasizes that Vermont has the highest percentage of people over 65 in the U.S.

Among other findings: 50 per cent of the 5,172 elderly citizens questioned are on Social Security, 16 per cent are on Old Age Assistance and 13 per cent on other retirement plans. Forty per cent say they would pay their doctors' bills through Blue Shield, and 28.9 per cent say they would foot the bill from savings or income.

The survey also revealed that doctors did not charge 2.3 per cent of the patients, and reduced charges in 12 per cent of cases, though Vermont MDs have the nation's lowest incomes.

Hospital Beds for Heart Cases

The need for hospital beds for patients suffering from heart disease, cancer and other long-term chronic diseases can be eased if government agencies will adapt existing facilities to their use, according to John A. Cowan, M.D., of the Michigan Department of Health.

Dr. Cowan listed tuberculosis sanatoriums, unused nursing residences and county medical care facilities as possible stop-gaps in expanding available hospital space for chronic disease patients. Dr. Cowan, director of the Division of Tuberculosis and Adult Health, noted that improved treatment of tuberculosis has caused a nationwide decline in the need for hospital beds for this disease.

"Although the average tuberculosis hospital is by no means ideal," he said, "it can be an acceptable substitute until such time as chronic disease hospitals can be financed and constructed."

"*ARE M.D.s TIGHT-FISTED?* The Louisiana State Medical Society, in a recent survey of all its members, found that the average doctor gives an estimated $3,531 annually in free medical care to 341 indigent patients; gives $1,098 in cash to charity."—*Medical Economics*, December 7, 1959.



6-10 HOURS
SUSTAINED THERAPY

ONE *and only ONE*

Timed AMO*dex* CAPSULE

PER DAY *will economically*

control appetite in weight reduction or relieve the nervous symptoms of anxiety and the underlying depression.

Timed AMO*dex CAPSULES* (Testagar) furnish a controlled uniform action. The medications provide prolonged, continuous therapeutic effect from active ingredients over a period of 6 to 10 hours.

Following ingestion of one *Timed* AMO*dex CAPSULE*, small amounts of the medication are released immediately.

Each *Timed* AMO*dex CAPSULE* contains a daily therapeutic dose of:

Dextro-amphetamine hydrochloride	15 mg.,
Amobarbital	60 mg.

AMO*dex* ADVANTAGES

- HIGH-LEVEL ANOREXIGENIC ACTIVITY WITHOUT NERVOUS EXCITATION
- SMOOTH, UNIFORM ACTION
- THERAPEUTIC EFFECT LASTING 6 TO 10 HOURS
- ONLY ONE DOSE DAILY
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PROTRACTED THERAPEUTIC EFFECT

Before the development of *Timed* AMO*dex* (Testagar) the usual dose of Dextro-amphetamine hydrochloride, for the control of appetite, was one 5 mg. tablet two or three times a day. The usual dose of Amobarbital ranged from 20 to 40 mg., two or three times a day. On such a dosage regimen the absorption of the drugs, after ingestion, takes place quite rapidly. The therapeutic activity occurs within one-half to one hour. When the therapeutic peak is reached, a gradual decline takes place. At this point, the patient should receive another dose of medication . . . the cycle is then repeated.

Patients frequently fail to follow the physician's instructions. They take medication at irregular intervals. When this occurs with drugs such as dextro-amphetamine sulfate, phosphate or hydrochloride, excitation may result. A balanced combination of Dextro-amphetamine hydrochloride, **the preferred salt,** plus a balanced daily dose of Amobarbital will give the expected therapeutic results *without* excitation.

Timed AMO*dex*, after ingestion, releases Dextro-amphetamine Hydrochloride and Amobarbital steadily and uniformly over a period of 6 to 10 hours. Therefore, the physician may dispense with the usual dosage schedule thereby *attaining better control of therapy*. The patient will receive the benefits of even and sustained therapeutic effects. Side reactions such as anxiety and excitation are greatly minimized.

ACTION AND USES

Timed AMO*dex CAPSULES* (Testagar) supply the antidepressant and mood-elevating effects of Dextro-amphetamine hydrochloride and the calming action of Amobarbital. *Timed* AMO*dex* elevates the mood, relieves nervous tension, restores emotional stability and the capacity for mental and physical effort.

Timed AMO*dex CAPSULES* are manufactured under these patent numbers:
2,736,682 – 2,809,916
2,809,917 – 2,809,918
Which provide prolonged, continuous therapeutic effect over a period of 6-10 hours

INDICATIONS

Timed AMO*dex* is the preferred treatment in anxiety states and in the management of obesity. *Timed* AMO*dex* may also be used in the treatment of Depressive states, Alcoholism, Nausea and Vomiting of Pregnancy.

DOSAGE The Daily Dose of *Timed* AMO*dex* (Testagar) IS ONE CAPSULE ON ARISING OR AT BREAKFAST.

SUPPLIED Bottles of 100 and 1000 capsules, available at all pharmacies. Also supplied in half strength as *Timed* AMO*dex*, Jr.

SAMPLES AND LITERATURE UPON REQUEST

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Carrying on congestion-free with fast-acting

NTZ®

NASAL SPRAY

At the first allergic sneeze, two inhalations from the **NTZ** Nasal Spray act speedily to bring exceptional relief of symptoms. The first spray shrinks the turbinates and enables the patient to breathe through his nose again. The second spray, a few minutes later, opens sinus ostia for essential ventilation and drainage. Excessive rhinorrhea is reduced. **NTZ** is well tolerated and provides safe "inner space" without causing chemical harm to the respiratory tissues.

NTZ is a balanced combination of three thoroughly evaluated compounds:

- **N eo-Synephrine® HCl, 0.5%** to shrink nasal membranes and sinus ostia and provide inner space
- **T henfadil® HCl, 0.1%** to provide powerful topical antiallergic action and lessen rhinorrhea
- **Z ephiran® Cl, 1:5000** (antibacterial wetting agent and preservative) to promote spread and penetration of the formula to less accessible nasal areas

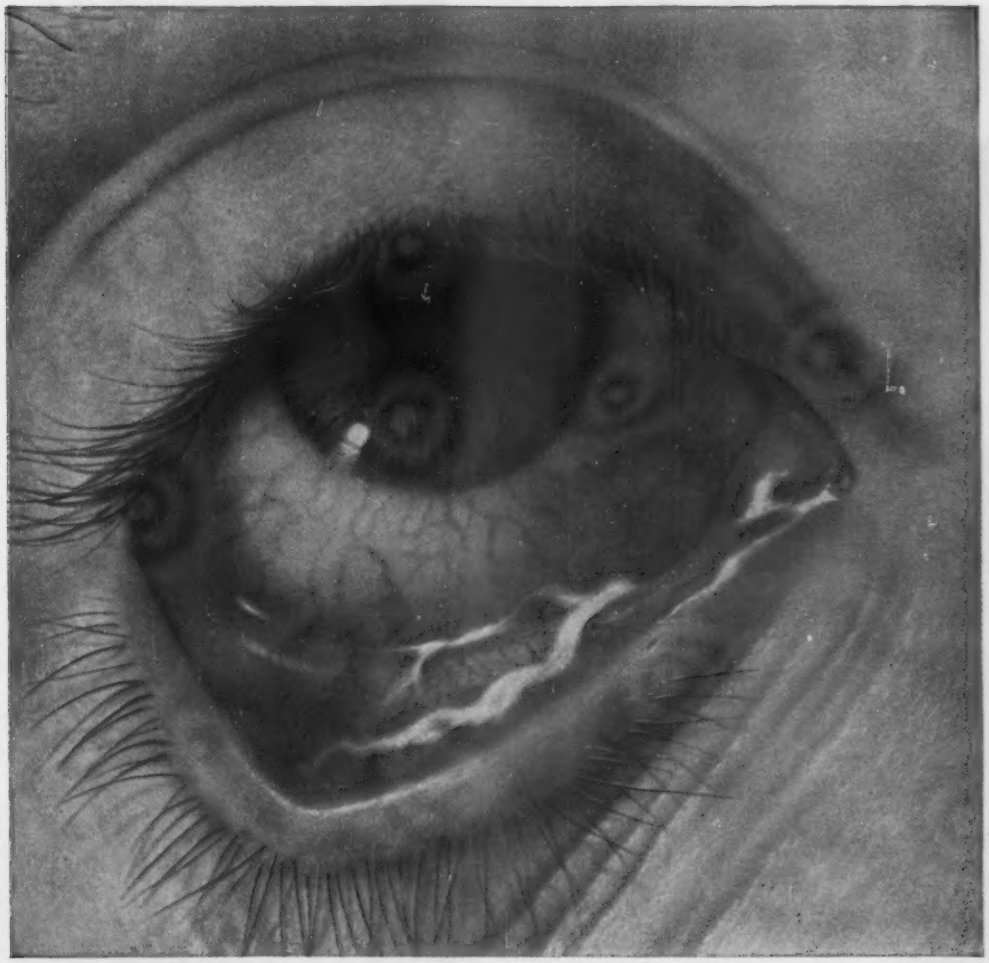
NTZ is supplied in leakproof, pocket size, squeeze bottles of 20 cc. and in bottles of 30 cc. with dropper.

QUICK SYMPTOMATIC RELIEF OF HAY FEVER OR PERENNIAL RHINITIS

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NTZ, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Say you saw it in the Journal of the Michigan State Medical Society



no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

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PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

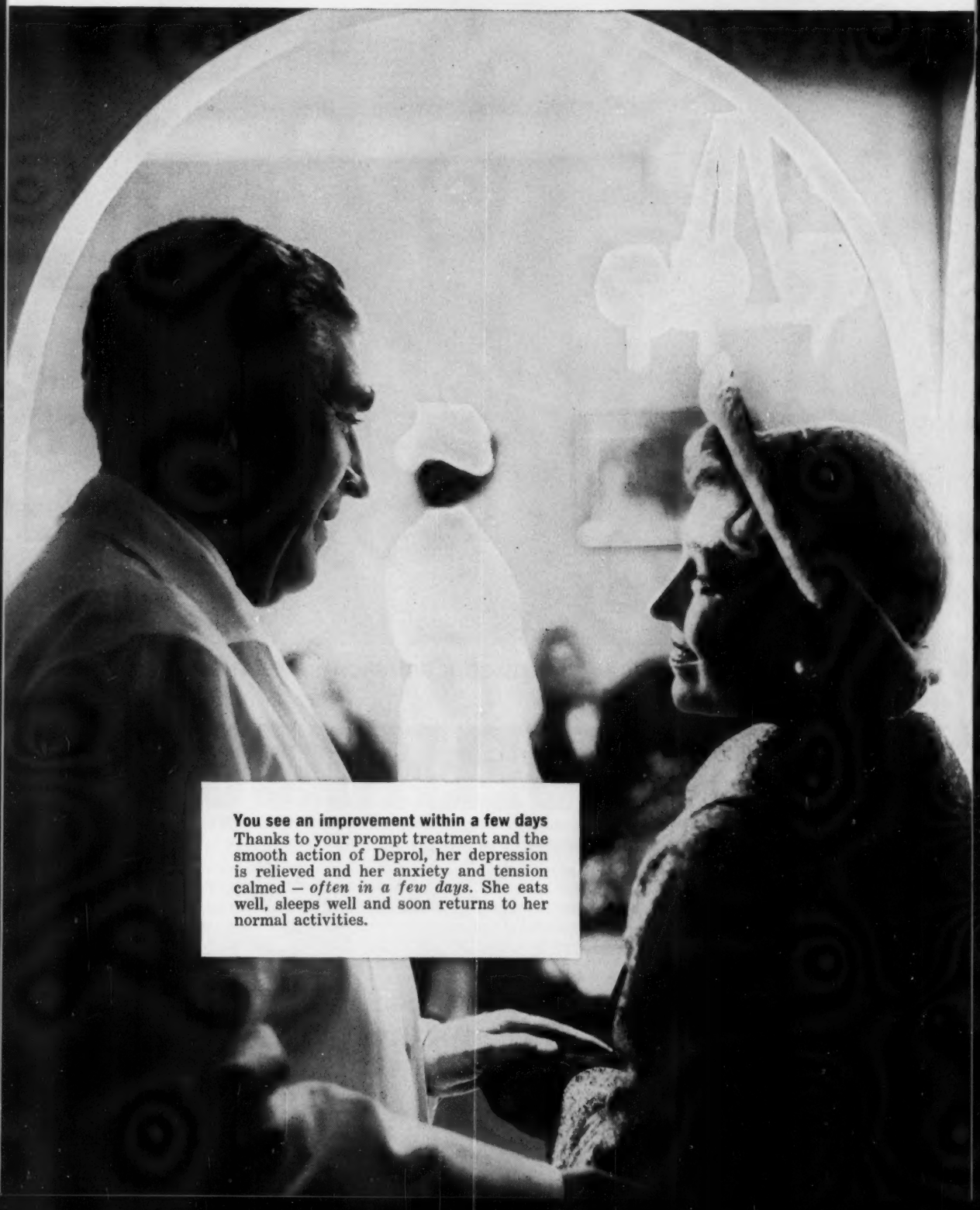
1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

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Lifts depression...



You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient *–they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation–*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety–both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function–frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

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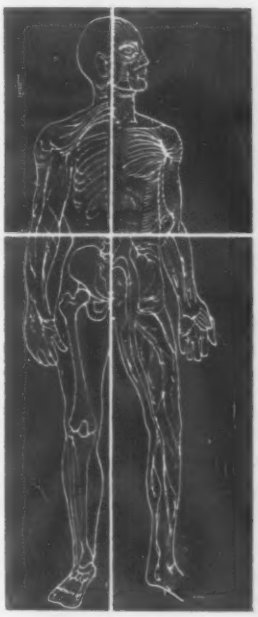
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Right Heart Catheterization

An Experience in Establishing this Technique in a Smaller Community and an Evaluation of its Contribution in the Local Management of Cardiologic Cases

H. E. DePree, M.D., F.A.C.P.
Kalamazoo, Michigan



THE IMPRESSIVE developments of the past ten years in the understanding and diagnosis of heart diseases have been to a large extent due to the elaboration of newer techniques of study as well as a clarification and newer interpretations of the results of older techniques. Many of these new techniques impose a requirement in terms of rather expensive and elaborate equipment and specially trained technical personnel. In addition, a new technical skill and a new physiologically oriented knowledge must be developed by the physician who would desire to perform and use these techniques. Consequently, these methods have largely been established only at the medical centers or in large cities. At the same time, the purpose of, and the stimulus for, the application of these more elaborate investigations have been the advent of feasible surgical therapeutic manuipulations. Many competent surgeons, well experienced in many of these established techniques of cardiac surgery, are being graduated from training in the recognized institutions. Many of these surgeons are establishing themselves in medium-sized communities throughout the country.

In 1954, as a practicing internist with a special interest in cardiovascular disease and encouraged by the thoracic surgeons, I decided to explore the possibility of establishing more definitive cardiovascular diagnostic techniques (initially, right heart catheterization) here in Kalamazoo. At that time this technique was only available at distant medical centers.

Several important considerations made the introduction of right heart catheterization to our community seem reasonable and important. First, the geographic location of Kalamazoo in the northeast corner of the southwest quarter of the state, in which area it is the largest city, provides the status of a minor medical center for the area. As a result, a considerable amount of clinical material is referred for consultation from surrounding small communities. Secondly, under the Michigan State Medical Society's rheumatic fever program an active local clinic had been operating for several years, and provided a source of many patients with congenital as well as rheumatic heart disease. Thirdly, patients referred for heart study to the centers at the University of Michigan, Detroit and in Chicago

were subjected to prolonged delays often because of the increasing volume of cases at these institutions. Finally, a well-trained thoracic surgeon entered practice in our community.

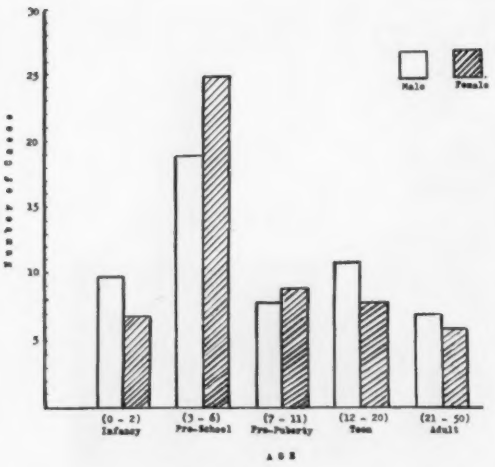


Fig. 1.

A progressive minded Board of Trustees of Bronson Methodist Hospital of Kalamazoo was convinced that a need for this technique existed and they generously agreed to set aside money for investment in equipment. Two laboratory technicians were selected and were trained in blood gas analysis at the Upjohn Company Research Laboratories in this city. An opportunity was arranged for me to spend one day a week at the laboratory of Dr. Benjamin Gasul at the Cook County Children's Hospital, Chicago, Illinois. I continued this training experience weekly for one and one-half years, so that I had performed fourteen catheterizations myself at the end of this period. My technicians also made several visits to Chicago to observe the procedures. We then made several "dry runs" with our own equipment and performed our first right heart catheterization in July 1956. The original technique was that of Cournand and Richards[1] but we soon modified our procedure slightly to include the use of the Cuvette oximeter as adapted by Wood[2] and in 1958 added the use of dye dilution curves.[3,4]



THE AUTHOR

H. E. DePree, M.D.

Figure 1 is a graphic summation as to age and sex of the first 110 cases studied with right heart catheterization in our laboratory. It is apparent that the largest group was in the pre-school age, reflecting, I believe, the uncovering of these cases so often in pre-school clinic activities. Sex distribution is overall about equally divided. These patients all come from within a radius of fifty miles of Kalamazoo. These patients had all been referred either to the Rheumatic Fever Clinic or to me. Clinical diagnosis before right heart study were arrived at after analysis of history and physical examination augmented by fluoroscopy and electrocardiographic study. At this point, a decision was made as to the need for catheterization. Table I is a tabulation of the various lesions encountered including a comparison with the frequencies in Paul Wood's reported series.[5] The incidence of many of the more common lesions in our experience is seen to be similar to the incidence in Wood's series, reflecting a fairly well rounded group of cases.

Since the ultimate desirable treatment of congenital cardiac lesions is anatomic surgical correction, all diagnostic manipulations are directed toward establishing whether or not surgical correctability exists, or is necessary. The final decision in this regard must of course be made by those who would perform the corrective procedure. We do not as yet have available in Kalamazoo a by-pass oxygenator pump for correction of lesions requiring this handling. Consequently, these lesions must be referred to "distant centers." If, in most cases, the decision for or against surgery could be made locally by the adjunct of right heart catheterization and/or angiocardiography, it would be possible to screen a large number of cases which would otherwise be required to have their work-ups prolonged at a "center" distant from home and consequently at added expense and inconvenience. Table II is an attempt to portray our experience as to the value of right heart catheterizations both in accuracy of diagnosis and in a decision regarding surgery. A very important dividend of our experience has been the development of an increasing accuracy of diagnosis clinically on the part of pediatricians, surgeons and all concerned in the handling of these patients locally, since right heart catheterization has been available. In Table II it can be seen that approximate-

ly 50 per cent of the cases were not diagnosed correctly clinically. Although it cannot be shown, this percentage was significantly lower in the latter part of the series. The grouping, "Clinical Diagnosis of Surgically Correctible Lesions before Catheterization" requires some explanation. This subdivision is designed to contain those cases which would ordinarily have been referred immediately to some "center" for possible surgical treatment. Consequently, it seems significant that of this group only 30 per cent were actually "referred for surgery" whereas 44 per cent were felt not to require surgery, and 36 per cent were found to be incorrectly diagnosed clinically when right heart catheterization was performed. Some patients fell into both of the latter groupings which explains the fact that the combined percentage of these two groups exceeds 70 per cent. A summation of the relative importance of right heart catheterization is attempted in the final classification in Table II. Here, cases falling into the group of those in which catheterization established no need or possibility for surgical correction, or an incorrect diagnosis, plus those surgical candidates unsuspected and uncovered and those in which important substantiation of contra-indicated surgical treatment, altogether yielded a total percentage of 73 out of the entire series of 110 patients. This would seem to amply demonstrate the importance of the procedure of right

TABLE I. LESIONS IDENTIFIED

Diagnosis after Catheterization	Number of Cases	Per Cent of Total	Per Cent Incidence in Congenital Heart Disease According to Wood*
Auricular septal defect and/or anomalous pulmonary veins**	17	15	17.5
Ventricular septal defect			
Predominant left to right shunt	13	12.8	10
Alone			
Predominant right to left shunt	2	1.8	3
Non-cyanotic	3	2.7	1.3
With pulmonic stenosis			
Cyanotic	5	4.5	
Pulmonary stenosis			
Isolated	14	12.7	11.5
With auricular defect	2	1.8	2.5
Patent ductus arteriosus	13	12.8	12.5
Common A-V canal defect	4	3.6	
Tricuspid atresia	2	1.8	
Complete transposition of the great vessels	1	1	1
Idiopathic dilatation of the pulmonary artery	2	1.8	1
Pulmonary hypertension, mild	2	1.8	
Aortic stenosis (by exclusion and pressure pulse contour)	8	7.2	3
Mitral stenosis	1	1	
Total anomalous pulmonary venous connection	1	1	("Rare")
Dextrocardia with associated anomalies	2	1.8	
Normal right heart catheterization findings	13	12.8	
Inconclusive result	5	4.5	
Total	110		

*Wood, Paul: Diseases of the Heart and Circulation, Lippincott, 1952.

**These lesions are considered together because distinction could not be made prior to the use of Dye-dilution curves and because they are often a combined lesion.

TABLE II. CLASSIFICATION OF RESULTS

	Number of Cases	Approximate Per Cent of Total
1. *Clinical diagnosis substantiated by catheterization	48	48
2. *Clinical diagnosis not substantiated (including normal findings)	50	50
3. *Clinical diagnosis of surgically correctible** lesion before catheterization	92	92
a. Referred for surgery after catheterization	31	31
b. Surgery found not immediately indicated, possible or necessary after catheterization	44	44
c. Clinical diagnosis found to be incorrect (including normal findings)	36	36
4. Number of surgically correctible** lesions found when clinical diagnosis a non-surgical lesion	5	5
5. Number in which catheterization substantiated clinical diagnosis of non-surgical lesion	5	5
6. Number in which catheterization made possible decision regarding surgical treatment (3b or 3c plus 4 plus 5)	73	73

(Inadequate or inconclusive right heart catheterizations have been omitted from the above classifications.)

*The "clinical diagnosis" here represents the most likely diagnosis on clinical or EKG evidence, or a group of likely clinical diagnoses.

**Surgical correctibility here is based on currently available surgical techniques, not necessarily those obtaining at the time of catheterization.

heart catheterization in the management of these cases.

The above remarks are made with the realization that increasing safety in the use of the by-pass oxygenator pump has for many surgeons increased the indication for surgical correction of congenital lesions and a determination of critical levels of disturbed hemodynamics such as can be discovered only through the procedure of catheterization may not always be necessary. In other words, a reasonably secure clinical diagnosis of ventricular septal defect uncomplicated for example may be indication enough for surgery in some clinics, just as is the case with patent ductus arteriosus uncomplicated. It has been our feeling, however, born from our experiences, that where the slightest doubt exists as to diagnosis or the presence of complicated dynamics, right heart catheterization is a safe procedure with a high degree of reliability and extremely useful. Of all patients coming to surgery or autopsy the catheter diagnosis was substantiated completely in twenty-nine and in error in two, making a percentage of accuracy of 93 per cent in this group. The number of unsatisfactory studies was five or 4.5 per cent.

In summary, the purpose of presenting this experience in the application of right heart catheterization in a smaller community is to show that this technique can be established and developed with the assurance of its providing good diagnostic reliability and considerable benefit in the local handling of cases of congenital heart disease, even though definitive treatment methods must largely be performed as yet at the more distant "centers." It is hoped that this presentation will be an encouragement to others in similar geographic circumstances and with a comparable medical situation.

References

1. Cournand, A., Baldwin, J. S., and Himmelstein, A.: Cardiac catheterization in congenital heart disease. pp. 4-26. New York: Commonwealth Fund, 1949.
2. Wood, E. H., and Geraci, J. E.: Photoelectric determination of arterial oxygen saturation in man. J. Lab. & Clin. Med., 34:387, 1949.
3. Wood, E. H., Swan, H. J. C., and Helmholz, H. F., Jr.: Recording and basic patterns of dilution curves. Proc. Staff Meet., Mayo Clin., 18:464, 1957.
4. Swan, H. J. C., Burchell, H. B., and Wood, E. H.: Special applications of indicator dilution technics in congenital and acquired heart disease. Proc. Staff Meet., Mayo Clin., 18:485 (Sept. 4) 1957.
5. Wood, Paul: Diseases of the Heart and Circulation. 2nd ed. pp. 318-471. Philadelphia: J. P. Lippincott, 1956.

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Biological Symposium

Biological warfare specialists, drug company representatives and scientists from the National Institutes of Health were among an estimated 400 virologists and biologists who attended the 11th annual Summer Biological Symposium at the University of Michigan, July 11-13.

Sponsored by the University of Michigan Division of Biological Sciences, the symposium concentrated on fundamental aspects of the nature of cell-life and the way it reacts to viral infections.

Participants included Dr. Pierre Fredericq, of the University of Liege, Belgium; Dr. Alfred Gottschalk, of the National University, Canberra, Australia; and prominent scientists from U. S. universities.

Prof. W. W. Ackermann of the University of Michigan School of Public Health was conference chairman.

Speakers developed such topics as the genetic interactions between viruses and cells; colesines (a killer-factor that attacks microscopic life); and the chemical and physical structure of viruses.

The purpose of the symposium this year was to show how viruses may be used to learn the functions of the cell.

The Treatment of Acute Volkmann's Ischemia

J. L. Kihm, M.D.
J. Hammer, M.D.
R. E. Delong, M.D.
R. L. Johnston, D.V.M.

Kalamazoo, Michigan

VOLKMANN'S ischemic contracture is an end-result of prolonged insult to soft tissues, in that muscles and nerves are denied nourishment required for their survival. In such a state soft-tissue infarction occurs, with later replacement by scar. While it is true that some salvage can be obtained from a limb so crippled[1] by excision of the infarct, the limb so affected is far from normal in appearance and function. The soft tissue of the limb must be saved *before* infarction occurs in the state of acute ischemia.



Fig. 1. Intramural hematoma in canine femoral artery directly between jaws of forceps, produced by crushing.

Acute Volkmann's ischemia is not a common condition, but it threatens whenever a humerus is fractured in the supracondylar region. In this area the proximal bone fragment displaces anteriorly to lie close to the brachial artery, which is found in rather snug fascial layers. Trauma to the artery may occur at the time of the fracture or at reduction and may initiate the chain of events leading to Volkmann's ischemia.

From Borgess Hospital, Kalamazoo, Michigan, and the Department of Pathology, The Upjohn Company, Kalamazoo, Michigan.

Pathogenesis

A recent review of the problem of threatened Volkmann's ischemic contracture[2] shows how the various theories of its etiologies have evolved and differed. Volkmann's original work on the topic in 1881 blames bandaging technique; but Murphy in 1914, Brooks in 1922, and Jepsen in 1926 were of the opinion that venous occlusion caused the changes. Subfascial hematoma caused the ischemia according to Moulonguet and Seneque in 1928, and Jorge in 1925. In 1940, Griffiths blamed spasm of the nutrient artery, and most recently Seddon has incriminated acute arterial primary occlusion.

Animal investigation has shown us that the actual picture varies. In the traumatized dog artery, occlusion may be due to intramural hematoma, which in many instances seems to cause and maintain arterial spasm. Figure 1 shows a freshly traumatized canine femoral artery, with both hematoma and spasm present. It is interesting to note at this point that while the spasm did appear to be somewhat relieved by the application of topical 2 per cent procaine to the artery, the swelling of the hematoma was not so relieved. Further investigation of traumatized canine arteries showed, however, that there was an additional cause of occlusion of the arteries. Figure 2 shows the marked proliferation of endothelium that marks later occlusion of the artery. While not as rapid in progression as the hematoma, endothelial proliferation is surprising in its vigor, and is a factor in cases of delayed block to circulation after arterial injury.

THE AUTHOR
J. L. Kihm, M.D.



It is our impression at the present time that acute Volkmann's ischemia is a result of direct trauma to the arterial wall by the fracture fragments of the humerus. Intramural arterial hematoma forms at the

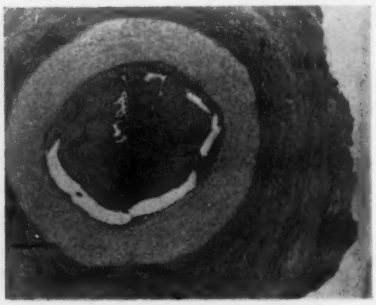


Fig. 2. Canine femoral artery, cross-section (20X), with endothelial hyperplasia response to trauma.

site of trauma, impeding circulation at this point. Collateral circulation is impeded by spasm and extrinsic pressure from fracture hemorrhage and edema under a tight fascial sheath. Muscles which are deprived of nourishment swell and further complicate the situation. It is precisely at this point that surgical intervention becomes mandatory to prevent soft tissue infarction and subsequent Volkmann's contracture.

Prevention of Acute Ischemia

For the sake of completeness, we mention various measures which have proved of value in routine management of the supracondylar fracture. Their value lies chiefly in promotion of venous and edema fluid drainage, and in keeping the patient available in case acute ischemia should occur. 1. Management of the supracondylar fracture by traction. 2. Immediate, anatomical reduction of the fracture. . . . gently. 3. Post-reduction hospitalization for close observation. 4. Avoidance of the acute flexion position of the elbow. 5. Avoidance of tight, encircling fixation. 6. Elevation of the extremity, and 7. Enzymatic aid in reduction of fracture hematoma and edema with systemic streptokinase-streptodornase or trypsin or chymotrypsin.

It is to be emphasized that none of these measures will be successful in the management of the acute ischemic phase prior to Volkmann's contracture.

The Clinical Syndrome of Acute Ischemia

The cardinal symptoms of acute ischemia are post reduction pain and restlessness. The child with a reduced supracondylar fracture of the humerous rarely needs more than aspirin for pain. In the presence of continued pain and unusual restlessness, and in the need for serial post-reduction narcotic injections, the presence of an impending or already present ischemic state in the extremity must be strongly suspected.

Signs of ischemia include pallor, cyanosis, or excessive swelling in the fingers. Capilliary fill in the nailbed is not a good sign in our experience, since the

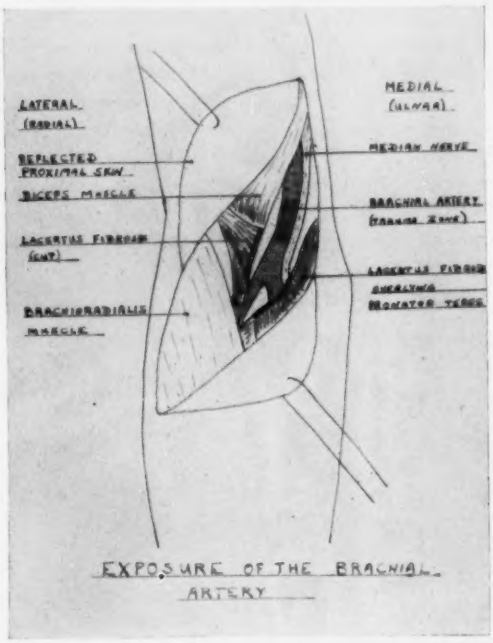


Fig. 3. Schematic sketch of surgical approach to brachial artery.

capillaries may fill well up to the time of muscle paralysis. Disappearance of radial pulse which has been present is an ominous sign, but when the fingers begin to lose motor and sensory function, acute ischemia is already present and spotty infarction has probably begun. At this point, surgical intervention must be sought if irreversible changes are to be avoided.

Management of Acute Ischemia

Under general anesthetic the antecubital fossa is opened with a "Z" shaped incision (Fig. 3). Lacertus fibrosus is opened over the course of the brachial artery, and clot and edema are evacuated from the vicinity to decompress the fascia. Radial pulse is constantly checked for return. The artery is exam-

ined gently and the point where pulsations cease is identified. This will be the site of mural injury in most cases, though retrograde spasm has been reported to have progressed proximal to it on occasion.

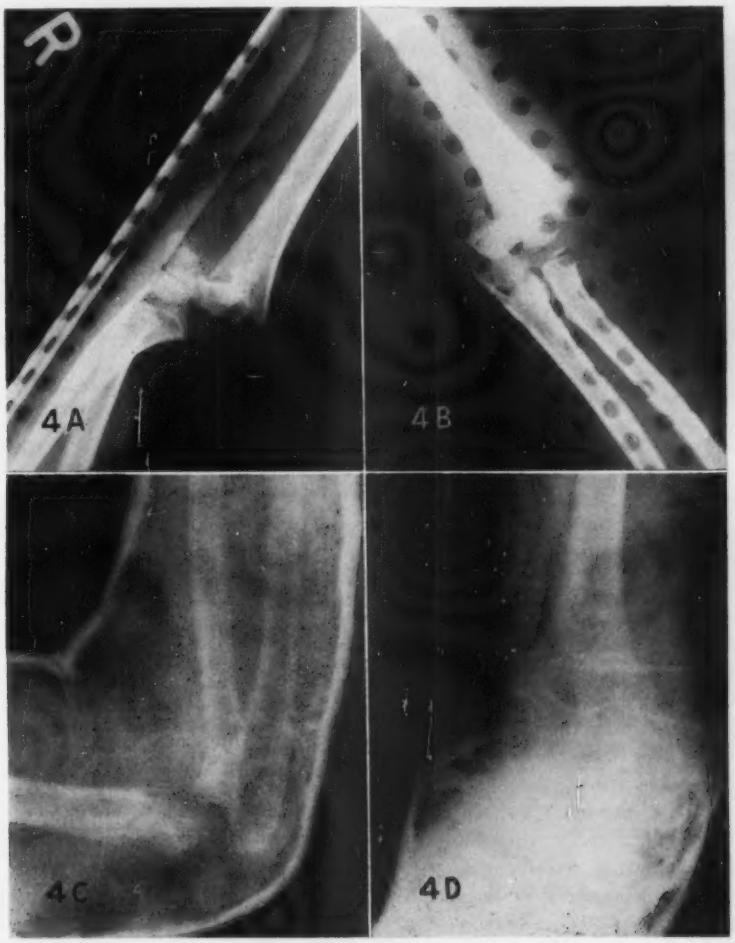


Fig. 4. (a) Lateral view right elbow, pre-reduction. (b) Anteroposterior view right elbow, pre-reduction. (c) Lateral view right elbow, post-reduction. (d) Anteroposterior view right elbow, post-reduction.

The artery at the level of the fracture will bear close scrutiny, however. With the fascia opened widely, warm packs and local anesthetic application may be applied to the artery, to try to return the radial pulsations at the wrist. In the absence of such return, a small arterotomy is performed longitudinally through the ecchymotic and swollen portion of the artery. If proximal blood flow is assured, the proximal artery is occluded momentarily with a vascular clamp. In the absence of retrograde flow, a small plastic catheter is introduced to the bifurcation of the artery and withdrawn with suction applied to the lumen. This will have the effect of removing small clots in the artery and of dilating its lumen. Retrograde flow should be re-established. A small piece of Gelfoam* is wrapped around the artery at the arterotomy site and gently held in place while the proximal arterial occlusion clamp is released. After a few moments the pulsation at the wrist should resume. Continuous gentle pressure on the Gelfoam wrap is maintained

*Gelfoam is a registered trade mark of The Upjohn Company.

for fifteen to twenty minutes, then released cautiously. If further bleeding from the arterotomy site occurs, manual pressure on the Gelfoam should be maintained until it stops.



Fig. 5. Case report; V. S. N., age six, eighteen months postoperative, showing ability to extend fingers, with slight residual weakness in extending right fifth finger.

The lateral limbs of the "Z" incision are then closed loosely and sterile dressings applied with a slight amount of pressure. A deflated tourniquet is placed above the operative site, to be inflated for temporary hemostasis should the Gelfoam clot be dislodged and post-operative hemorrhage occur. Needless to say, observation of the patient must be continuous until delayed closure of the incision can be carried out in six or seven days. The fractured arm is placed in nearly full extension in a posterior splint during the time of healing of the arterotomy wound, though the position and fixation may be determined by surgical judgment at the time of operation.

Prophylactic antibiotics are rational in the presence of an open wound, and vasodilators likewise seem desirable. Remanipulation of the fracture may be necessary postoperatively after the antecubital incision is closed, but one must bear in mind that moderately great degrees of displacement on the x-ray will heal kindly according to Wolff's Law if rotation and lateral angulation are controlled. Function of the extremity will improve over the course of a year or more, and should be assisted by dynamic splinting and physiotherapy where required.

Case Report

V. S. N., a six-year-old school girl, was admitted to the Borgess Hospital emergency room within an hour after having fallen onto her right arm. Her sole injury appeared to be a supracondylar fracture of the right humerus, but the radial pulse was absent on admission. Within an hour after admission, a gentle closed reduction of the humerus had obtained an anatomical position of the fracture fragments (Fig. 4). A radial pulse was obtained post-reduction with the elbow at a right angle, and the extremity in a long-arm cast. She was admitted to the hospital for observation, and required 20 mgm. Demerol* in three hours.

Twelve hours later the fingers were warm with good sensation and she could move them, though slight swelling was present. However, during the next twelve hours she required five more injections for pain in the extremity. Thirty-six hours post reduction more pain and restlessness were present, so the cast was split and spread. Finger warmth, motion, and sensation had remained present to this time, but soon she could no longer move the fingers and the radial pulse disappeared.

The hand was watched for improvement for a few hours and when none was forthcoming, the cast was removed and the elbow extended. The arm then went into a posterior split. The condition of the extremity deteriorated and by forty-eight hours post reduction there was pain on passive extension of the fingers with loss of hand sensation and active motion.

She was taken to surgery where the procedure outlined above was followed. The antecubital fossa was filled with clot and edema, which was evacuated. The brachial artery was pulseless and in spasm distal to a small ecchymotic area in its wall at the level of the fracture and 1½ inches proximal to the brachial artery bifurcation. Hot packs were placed in the wound and though the peripheral spasm appeared to decrease, the radial pulse did not reappear.

Accordingly, through the ecchymotic area where the pulse disappeared, a longitudinal arterotomy was performed, 2 mm. in length. Bleeding from the proximal artery was brisk, so it was gently occluded. There was no back bleeding. A No. 20 polyethylene catheter was introduced distally to the bifurcation and withdrawn with suction. Back bleeding occurred though no clot was ever seen in the suction tube. A piece of Gelfoam was wrapped about the arterotomy and held in place and the proximal clamp released. Gradually the radial pulse returned and the hand warmed. Finger pressure on the Gelfoam closure was maintained for about twenty minutes, releasing it intermittently to see if bleeding would occur beneath it. When such bleeding was negligible, the lateral and medial limbs of the skin incision were closed loosely, with a Vaseline pack centrally. Further post operative care followed as outlined above.

There was much improvement on the first postoperative day, with a radial pulse, decreased hand edema, and good color. No active finger motion or finger sensation were present, however, and the patient complained of paresthesias. A small amount of postoperative narcotic easily controlled pain, less than the pre-operative (post-reduction) being needed. On the second and third days there was spotty sensory return, and early motion. Improvement continued and on the sixth day the incision was cleaned and closed under general anesthesia. X-rays taken at this time showed re-displacement of the fracture, so on the ninth day the fracture was remanipulated, the position being altered only slightly. A long arm plaster was applied with the elbow in flexion and the patient discharged. Two weeks later saw the removal of the cast and the institution of active motion to the whole extremity. At the time of cast removal, however, she had finger flexion contracture, but good active mo-

*Demerol is a registered trade mark of the Winthrop Laboratories.

tion and sensation in the hand. Dynamic splinting with physiotherapy of whirlpool and active and passive motion of the fingers was carried out for six months. It was then discontinued because of the excellent progress. At the time of publication (eighteen months postoperative) she lacks only twenty degrees of full supination at the wrist and a few degrees of extension in the fifth proximal interphalangeal joint (Fig. 5).

Discussion

The key to success in cases of acute ischemia is to be able to get in and out of the artery involved without occluding it. Small arteries, particularly those which have been recently traumatized, are particularly prone to thrombosis when they are nearly occluded by the suture of a closure. It is necessary to have at hand a means to effectively close the small vessel of a child without occlusive suture, since a thrombosis postoperatively would defeat the purpose of the arterotomy.

Jenkins and co-workers[3,4] have shown that the great thoracic vessels and even the heart may be effectively closed by a fibrin foam clot when lacerated. Our animal work has substantiated this (Fig. 6) and has shown that firm healing occurs beneath the Gelfoam, without bulging of the scar or aneurysm formation. We therefore feel that this principle may be applied in other instances of arterotomy where it is desirable to preserve the blood flow through a rather small vessel.

Summary and Conclusions

1. The etiology, symptomatology, anatomy, and pathogenisis of acute Volkmann's ischemia are discussed, with a rationale for the management of the condition.

2. Animal procedures have been carried out, testing the efficacy of Gelfoam arterotomy closure.

3. Case presentation of the successful management of acute Volkmann's ischemia using Gelfoam arterotomy technique has been made.

4. The desirability of application of this technique to other small vessel laceration or arterotomy is suggested.



Fig. 6. Canine femoral artery, fourteen days after having arteriotomy closed with Gelfoam pledget, showing remnant of incision in media, mature scar over incision, and remaining Gelfoam fragments at far right.

Acknowledgment

We wish to express gratitude to Paul Rutherford, M.D., for his assistance with photography and to The Upjohn Company for assistance with the animal research.

References

1. Seddon, H. J.: Volkmann's contracture: treatment by excision of the infarct. J. Bone & Joint Surg., 38B:152, 1956.
2. Benjamin, A.: The relief of traumatic arterial spasm in threatened Volkmann's ischemic contracture. J. Bone & Joint Surg., 39B:711, 1957.
3. Jenkins, H. P., Senz, E., Owen, H., and Jampolis, R.: Control of arterial hemorrhage by a gelatin sponge "cuff" and chronic surgical gut sheath. Arch. Surg., 55:637, 1947.
4. Jenkins, H. P., Senz, E., Owen, H., and Jampolis, R.: Control of hemorrhage from wounds of the heart by the gelatin sponge "patch" technic. Annals Surg., 126: 973, 1947.
5. Hammer, J., and Johnston, R.: Personal communication.

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Gift To Beaumont Memorial Library

Irving F. Burton, M.D. and Coleman Mopper, M.D., have made a gift of a rare book to the Beaumont Memorial Library on Mackinac Island.

A military journal during the American Revolutionary War, From 1773 to 1783; Describing Interesting Events and Transactions of this Period; with numerous Historical Facts and Anecdotes, an appendix containing Biographical Sketches of several General Officers. By James Thacher, M.D. Late Surgeon in the American Army. Second Edition, Revised and Corrected. Boston: Published by Cottons and Barnard, 184 Washington Street. John Cotton, Printer 1827. 477 pages.

This volume has been placed in the Beaumont Memorial Library section on historical source material for the use of those interested in the military historical period of the Revolutionary War.

Staphylococcus Enterocolitis

Robert H. Hume, M.D.
Kalamazoo, Michigan

DURING recent years, physicians have become concerned with the problem of disease caused by the staphylococci. Diseases of the gastrointestinal tract are but one of the evidences of its presence. Here the organism shows a wide range of disease, from the effects of staphylococcal food poisoning, with a high rate of recovery, to pseudo-membranous enterocolitis, with a very low rate of recovery.

Recently more attention has been focused on the problem of pseudomembranous enterocolitis. It has been suggested that this problem is generally confined to those patients who have had a course of antibiotics,[1,2] or who have recently undergone some form of surgical operation, usually of an abdominal nature.[3] It was pointed out by Pettet at the Mayo Clinic in 1954 that they had observed and proven microscopically the diagnosis of pseudomembranous enterocolitis in forty-five hospital patients prior to the advent of antibiotics in 1938.[3] Other authors have reported cases developing in persons who have not had any form of surgical operation.[4] To Dr. Finney of the Johns Hopkins Hospital goes the honor of describing in American literature the first patient with this particular disease in 1893.[5] In his report, a twenty-two-year-old Negro girl died fifteen days following a gastroenterostomy. For five days prior to death, she had had severe persistent diarrhea. The diagnosis was proved at necropsy.

Information gained from autopsy as well as information gained in recent years by laboratory examination suggests that the organism staphylococcus and more specifically *Staphylococcus aureus,* is the etiologic agent of this problem. This group of organisms elaborates several toxins or enzymes. The ability of the staphylococcus aureus to produce disease is thought to involve one of the following: 1. The organism elaborates a substance that plays a direct role in its aggression and serves to neutralize the defenses of the host.[6] 2. Mutants of the organism are formed which are capable of living and developing in the face of either a normal intestinal flora or in one somewhat altered by antibiotics.[7] Having established itself and started to reproduce, the organism now elaborates an enterotoxin in increasing amounts. Surgella, in an interesting study, obtained micrococcus stool cultures from the patients with a diagnosis of enteritis and in turn isolated from the cultures an enterotoxin.[8] This material was then administered orally to monkeys who showed signs suggestive of toxicity on 90 per cent of the tests.



THE AUTHOR
Robert H. Hume, M.D.

Just as there are a number of different strains of staphylococcus capable of producing an enterotoxin, so there must be some variation in the potency of the elaborated toxin and therefore the symptoms produced. An organism producing a toxin, as often observed in staphylococcus food poisoning, might be of relatively low virulence. It is destroyed after ingestion and further toxin is not elaborated. At the other extreme, an organism capable of living and producing a highly toxic substance while in the intestinal tract might well result in signs and symptoms of severe enterocolitis or pseudomembranous enterocolitis.[9] J. H. Johnson has summarized his experience with severe enterocolitis and pseudomembranous enterocolitis.[9] He observed that this disease was of three types.

1. *Choleric Type.*—This is probably most often recognized. The patient has symptoms of watery diarrhea, nausea, vomiting, abdominal cramps, abdominal distention and fever.

2. *Ileus Type.*—The patient demonstrates increasing abdominal distention that does not respond to gastric suction. Material gained by suction consists of copious amounts of greenish-brown fluid. There is associated nausea and vomiting. Frequently, there is respiratory embarrassment.

3. *Precipitous Shock Type.*—There is a rather sudden appearance of mild to moderate shock, tachy-

cardia, pallor, sweating, and dyspnea. They may have diarrhea, abdominal distention, nausea, and vomiting.

Kalamazoo Experience

Between 1956 and 1960 we have had twelve patients in the Bronson Methodist Hospital in Kalamazoo, Michigan, who have illustrated the comments mentioned above. Many patients entered the hospital with the clinical diagnosis of staphylococcal food poisoning. There was only one patient who was admitted after ingestion of proven contaminated food, in which subsequent stool and sputum cultures also showed *Staphylococcus aureus*. The diagnosis of staphylococcus enterocolitis was proven in five patients, and presumptive in one patient. Pseudomembranous enterocolitis was a clinical diagnosis in five patients, but was proven in four patients by necropsy. It has been repeatedly pointed out that the gaining of positive stool cultures is always difficult. The symptoms are the result of the toxin. As a result, cultures may be taken at times when the organism is not present in the stool, or cultures may be made with insufficient attention to isolation of staphylococci. The milder forms were associated with symptoms which improved with medical attention. The more virulent cases improved, but only after vigorous and prolonged treatment. The very severe cases, however, had all the evidence of fulminating disease, and in spite of vigorous attention, each one died.

Case Reports

Case 1.—B. S. This nineteen-year-old girl had turkey for supper which was later proven by the County Health Department to be infected with staphylococcus. Shortly thereafter, she had the onset of severe headache, profused diarrhea, and severe vomiting. Cultures of sputum and stool were positive for hemolytic coagulase positive *Staphylococcus aureus*. Over a period of thirty-six hours, on a supportive program, not including antibiotics, she improved and was discharged.

Case 2.—G. I., a six-month-old child, was treated in the hospital for pneumonia. During this period, she received tetracycline, chloromycetin, and penicillin.® Ten days following discharge, she developed diarrhea with copious watery stools. Stool cultures showed a non-hemolytic staphylococcus. On a program of chloromycetin and supportive therapy, improvement took place.

Case 3.—N. C., a twenty-four-year-old, allergic, woman, gave a five day history of four to six loose stools containing blood and pus. Stool cultures grew *Staphylococcus aureus*. On a supportative program not including antibiotics, she improved and was discharged.

Case 4.—J. M., a sixty-four-year-old woman, was admitted to the hospital with the diagnosis of coronary thrombosis. Four days after entry, she had the onset of griping abdominal pains, a temperature of 103° F., and four liquid brown stools per day. Stool cultures showed a non-hemolytic staphylococcus, coagulase negative. On a vigorous program, including antibiotics, penicillin, tetracycline, streptomycin, and albamycin®, she showed steady improvement over a period of one week.

Case 5.—R. G., a sixty-five-year-old-woman, was given a course of twelve tetracycline capsules® in October, 1957. Twelve days following this, she noted severe general abdominal discomfort. This was in turn followed by a temperature of 103.6° F., pulse of 110, vomiting, nausea, and eventually two to seven brown liquid stools per day. A stool culture grew staphylococcus albus. She was placed on a program of erythromycin, chloromycetin, and tetracycline®. She showed definite improvement. Because of persistent right lower quadrant discomfort, she was operated upon. Five hundred cc. of fluid were removed from the abdomen, but no abscess was observed. A decompression cecostomy was performed. She subsequently slowly improved.

Case 6.—J. V., a seventy-three-year-old man was admitted for treatment of a stasic ulcer. Following a period of preparation for surgery, including the use of penicillin and tetracycline, the ulcer was skin grafted. Two days following operation, vomiting and abdominal distention were observed. His temperature rose to 101° F. and he had diarrhea of two to four stools each day. Throat and stool cultures showed *Staphylococcus aureus*, coagulase positive, phage type 47, 53, 54, and 73. He was placed on a vigorous antibiotic program of erythromycin, mycostatin, and neomycin with steady improvement and recovery.

Case 7.—E. C., a forty-one-year-old woman, had a subtotal gastric resection performed in April, 1956. Following operation she developed severe abdominal distention and pain associated with a temperature of 104.8° F., pulse of 160, and respirations of 24. Subsequently, she had several loose watery stools. It was felt that she had developed a gastrocolic fistula, and she was therefore returned to the operation room two days following her original operation. Post-operatively, she went into a severe shock state. She was maintained on vasopressure agents, steroids, fluids, and chloromycetin, penicillin, and streptomycin®. During this period she had four to six foul green liquid stools per day which grew Gram-positive streptococcus when cultures were made. Her physical state slowly stabilized and subsequently, she made steady improvement.

Case 8.—A fifty-two-year-old woman, had a left thalamotomy performed in August, 1959. She was given no antibiotics. On her eighth postoperative day, she told of severe abdominal discomfort and distention. Her temperature rose to 103° F., with a pulse of 100 and respirations of 28 per minute. It was felt that clinically she had experienced some form of acute abdominal catastrophe. She was operated upon. Examination of a smear made from the intestine at the time of operation showed Gram-positive cocci. The serosal surfaces appeared to be dull and had great vascular congestion. A segment of yellow-gray necrotic appearing ileum was resected. Subsequently, she went into vascular collapse with a temperature rise to 105° F., and she expired. Histologic examination of the intestine showed a dense fibrino-purulent exudate, necrosis of mucosa, and most important of all, colonies of microorganisms which represented staphylococcus.

Case 9.—E. B., a seventy-two-year-old man, had a vesicle neck resection performed in November, 1956, from which

he convalesced satisfactorily. Two months following discharge, while at home, he had the onset of temperature to 102° F., abdominal discomfort and diarrhea. After admission to the hospital in January, 1957, he was started on tetracycline and erythromycin®. In spite of this he rapidly became worse and died. An examination of a swab taken from the lumen of his colostomy prior to death, showed Gram-positive cocci. A blood culture was negative. No autopsy was obtained, but clinical diagnosis was pseudomembranous enterocolitis.

Case 10.—A. J. Z., a sixty-six-year-old man, had a subtotal gastric resection for duodenal ulcer in April, 1956. On his second postoperative day, his abdomen became firm, tender, and his temperature rose to 104° F. This was in turn followed by the passage of a number of watery brown stools. He was given penicillin, streptomycin, teramycin, and tetracycline®. He died on his third postoperative day. Cultures taken at the time of autopsy showed multiple pure cultures of *Staphylococcus aureus*. The mucosa of the ileum and jejunum was necrotic. The serosa was gray with marked congestion of the vessels. Microscopic examination showed complete necrosis of the mucosa with many colonies of bacteria.

Case 11.—L. D., a seventy-eight-year-old woman, was admitted to the hospital with a diagnosis of acute cholecystitis. On a conservative program which included the use of chloromycetin® she slowly improved. Subsequently, a cholecystectomy and exploration of the common duct was performed. On her fourth postoperative day, she developed a temperature of 102.6° F., a pulse of 110, and respirations of 38 per minute. Marked abdominal distention with generalized abdominal tenderness and signs of diminished blood volumn were observed. She was vigorously treated with blood, fluids, steroids, and chloromycetin®. In spite of this, she rapidly declined and died. At autopsy, the small intestine was filled with fluid, the serosa was dull with marked venous congestion. Microscopic examination showed multiple areas covered by a diptheritic membrane in which colonies of staphylococci could be identified.

Case 12.—J. K., a one-week-old girl, was born with a rectoperineal fistula. It was discharged on the fourth day of life, passing stool adequately from its fistula and tolerating an adequate formula. Two days following discharge, she passed no stool and took one half ounce of formula orally. After re-admission to the hospital, a catheter was inserted into the rectum and 40 cc. of foul smelling liquid stool removed. Eight hours after admission the child died. At autopsy, areas of fibrin were noted on the intestinal surface. The entire mucosa of the large intestine was represented by a grayish brown membrane which could be easily stripped from the underlying tissue. Microscopic examination confirmed the presence of a fibrino purulent exudate overlying the submucosa. Colonies of bacteria could be also seen.

Discussion

Staphylococcus enterocolitis is a disease which may appear in any one either in or out of the hospital and in those who have had or those who have not had an operation. Six of our twelve patients developed their symptoms at home prior to hospital admission. Six developed their symptoms while in the hospital. Five patients had undergone a recent surgical operation of which three were abdominal in nature. Four had had a recent course of antibiotics, while eight patients had not received any antibiotic medication prior to the onset of their symptoms.

At the time the organism is introduced into the intestinal tract, there must be some changed resistance on the part of the host increasing susceptability to the organism and its toxin. Under this condition, the organism is able to grow easily, pushing out the normal flora and elaborating its own virulent enterotoxin in ever-increasing amounts.

The severity of the symptoms presented appears related to the severity of the infection, and therefore the virulence of the enterotoxin produced. Under suitable circumstances, the organism has been cultured and the enterotoxin obtained and tested in laboratory animals as done in the studies of Surgella.[8] Even more important information has been added by Prohaska.[10] Prohaska obtained *Staphylococcus aureus* cultures from patients who had a clinical diagnosis of pseudomembranous enterocolitis, or from food definitely implicated in human poisoning. He in turn administered orally to antibiotic treated rabbits the cultures. The enterotoxin produced by the cultures were also given to other rabbits. Many of the rabbits subsequently developed symptoms suggestive of pseudomembranous enterocolitis. Autopsy examination confirmed the diagnosis in both rabbits given the cultures and in the rabbits given the enterotoxin. He concluded that the changes observed in the bowel and fatal termination of the disease is due to the enterotoxin produced.

Treatment in these patients must be prompt and vigorous. Careful attention must be given to adequate fluid replacement since these patients may lose many liters of electrolyte a day. Antibiotics must be given on the basis of sensitivity studies. Erythromycin and albamycin® appear at this time to be most helpful. Steroids in large dosages are said to be helpful.[11-12] Vasopressor drugs may be needed.

Efforts can be made to innoculate the intestine with a more normal flora. Lactobacillus has been given by mouth. Possibly, one might consider inoculating the colon by use of enemas of stool from healthy individuals, or of stool cultures known to contain normal flora. In mild cases, vigorous treatment is associated with recovery. In the fulminating cases, the outlook is poor in spite of vigorous treatment.

Summary

1. Toxin producing staphylococci, when they gain entrance to the gastronintestinal tract, are capable of producing serious disease.

2. The disease presentation depends on the virulence of the enterotoxin produced.

3. Staphylococcal poisoning, staphylococcal enterocolitis, and pseudo-membranous enterocolitis are probably related diseases.

4. Treatment, if prompt and vigorous, will usually result in recovery in the less fulminating cases. In full bloom clinical pseudo-membranous enterocolitis the outlook is poor with our present means of treatment.

References

1. Jackson, G. G., Haight, T. H., Kass, H., Womack, C. R., Gocke, T. M., and Finland, M.: Terramycin therapy in pneumonia—clinical and bacteriologic studies in 91 cases. Ann. Int. Med., 35:1175, 1951.
2. Editorial: Antibiotics, staphylococcal enteritis and pseudo-membranous enterocolitis. New England J. Med., 249:37, 1953.
3. Pettet, J. D., Baggenstoss, A. H., Dearing, W. H., and Judd, E. S.: Postoperative pseudo-membranous enterocolitis. Surg. Gynec. & Obst., 98:546, 1954.
4. Kleckner, M. S., Jr., Bagen, J. A., and Baggenstoss, A. H.: Pseudomembranous enterocolitis: Clinical pathologic study of 14 cases in which the disease was not produced by an operation. Gastronenterol., 21:212, 1952.
5. Finney, J.: Gastro-enterosotomy for cicatrizing ulcers of the pylorus. Johns Hopkin's Hosp. Bull., 4:53, 1893.
6. Dubos, R. J.: Bacterial and Mycotic Infections of Man. 3rd ed., p. 317. Philadelphia: J. B. Lippincott Co., 1958.
7. Paine, J. R.: Staphylococcus enterocolitis. Nebraska M.J., 43:433, 1948.
8. Surgella, M. J.: Enterotoxin produced by micrococci from cases of enteritis after antibiotic treatment. J.A.M.A., 158:649, 1955.
9. Johnston, J. H.: Pseudomembranous enterocolitis. Surgery, 39:375 and 79:197, 1956.
10. Prohaska, J. V.: Pseudomembranous enterocolitis. Arch. Surg., 97:197, 1956.
11. Spink, W. H.: ACTH and adrenocorticosteroids and therapeutic adjuncts in infectious diseases. New England J. Med., 257:979, 1957.
12. Prohaska, J. V., Govostis, N. S., and Tauberhaus, M.: Post-operative pseudomembranous enterocolitis. Successful treatment with corticotropin. J.A.M.A., 154:320, 1954.

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Accurate Labeling of Drugs

Stronger regulations to insure that physicians receive adequate information about the drugs they prescribe and to insure the safety of new drugs have been proposed by the Food and Drug Administration.

The new regulations would:

1. Require sweeping changes in the labeling of prescription drugs. Virtually all prescription drug packages and printed matter distributed to physicians to promote sale of a drug would be required to bear complete information for professional use of the drug, including information about any hazards, side effects or necessary precautions.

2. Provide that when safety requires, a new drug would be kept off the market until the manufacturer's representations regarding the reliability of manufacturing methods, facilities and controls have been confirmed by a factory inspection by the Food and Drug Administration.

Other proposed labeling changes would require drugs for injection and for use in the eyes to bear a quantitative declaration of all inactive ingredients. Labels of all prescription drugs would be required to include an "identifying lot or control number from which it is possible to determine the complete manufacturing history."

The Diagnosis and Treatment of Subphrenic Abscess

G. Allen Rogers, M.D.
A. J. Neerken, M.D.
Kalamazoo, Michigan

In spite of the effectiveness of antibiotic drugs in many infectious processes, subphrenic abscess continues to be an important complication of abdominal surgery. Due to the relatively inaccessible location and the protection afforded by the thoracic cage, infection below the diaphragm has been difficult to diagnose and to treat.[1] These lesions follow a suppurative process within the abdominal cavity and the treatment of the condition is primarily surgical. Ochsner points out that infections of the subphrenic space occur much more frequently than is commonly supposed, but fortunately many times may subside spontaneously with the diagnosis never having been suspected.[2] However, the seriousness of a collection of pus beneath the diaphragm is emphasized by the study of Faxon who reported a fatal outcome in approximately 90 per cent of cases not surgically drained.[3]

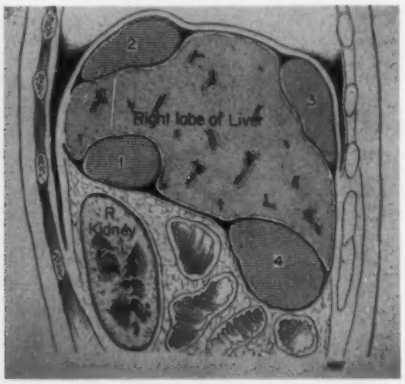


Fig. 1. (1) Right posterior subhepatic abscess. This site may be readily drained extrapleurally and extraperitoneally below or through the bed of the resected twelfth rib (Ochsner). (2) Right posterior subphrenic abscess. (3) Right anterior subphrenic abscess. The approach to this part of the subdiaphragmatic space is a subcostal incision on the right going extraperitoneally and extrapleurally (Ochsner). (4) Typical right anterior subhepatic abscess easily reached through the existing right rectus or subcostal incision. (Boyd, David: Surg. Clinics of North America, June, 1958, W. B. Saunders Company.)

History

Barlow in 1845 first described the condition of subphrenic abscess.[4] Some forty years later, Leyden again described the clinical picture.[5] In 1875, Volkmann recorded an operation for subphrenic abscess and in 1907 Barnard published the classical anatomical description of the subphrenic space which has been widely accepted and reproduced in many standard textbooks.[6]

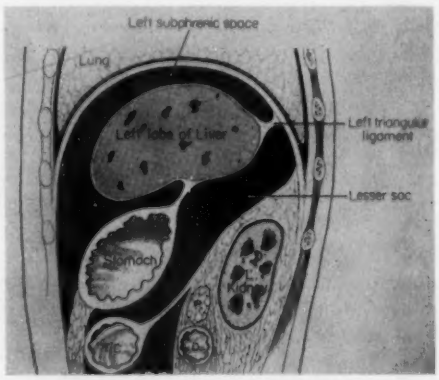


Fig. 2. Sagittal section through left lobe of liver near falciform ligament. As one passes farther to the left the separation into subphrenic and subhepatic areas is less distinct. Removal of a section of the eleventh or twelfth rib will give direct access to the lesser sac. The relationship of the lesser sac to the diaphragm is emphasized. (Boyd, David: Surg. Clinics of North America, June, 1958, W. B. Saunders Company.)

Anatomy

In a report which simplifies the complex and confusing anatomical and pathological descriptions of the

From the Department of Surgery, Bronson Methodist Hospital, Kalamazoo, Michigan.

TABLE I. SUMMARY OF CASES IN PRESENT REPORT

No.	Age	Sex	Original Lesion	X-Ray Findings	Drainage Technique	Location of Abscess	Result
1	42	F	Perforated duod. ulcer	Elevated diaph. Air bubble	Rt. subcostal extraperitoneal	Right subhepatic	Recovered
2	55	F	Perforated peptic ulcer	Elevated diaph. Limitation diaph. Air-fluid level	Transthoracic (Trardelenberg)	Right subphrenic	Recovered
3	37	M	Perforated marginal ulcer 2 yr. post gastrectomy	Elevated diaph. Air bubble	Left subcostal extraperitoneal	Left subphrenic	Recovered
4	59	M	Duodenal stump leak, post gastrectomy	Contrast media instilled into sinus tract and subphrenic abscess	Rt. subcostal extraperitoneal	Right subhepatic	Recovered
5	57	M	Duodenal stump leak, post gastrectomy	Elevated diaph.	Rt. subcostal extraperitoneal	Right subphrenic	Recovered
6	51	M	Duodenal stump leak, post gastrectomy	Not diagnostic	Subcostal exploration	Right subhepatic Left subphrenic (massive abscess)	Died
7	47	M	Ruptured appendix	Elevated diaph. Pleural fluid	No surgery performed. Antibiotic therapy	Left subphrenic	Recovered
8	18	M	Ruptured appendix	Air bubble. Pleural fluid	Retroperitoneal through bed of 12th rib	Right posterior subhepatic	Recovered
9	9 mo.	M	Ruptured appendix	None taken	Transperitoneal	Right subphrenic	Recovered
10	62	M	Ruptured appendix	Elevated diaph. Gas bubble Pleural reaction	Transperitoneal	Right subphrenic	Recovered
11	43	F	Splenectomy	Pleural exudate left base	Left subcostal extraperitoneal	Left subphrenic	Recovered
12	65	F	Splenectomy	Fluid-air level. Limitation motion of diaph. Pneumonitis and pleuritis l. base	Left subcostal extraperitoneal	Left subphrenic	Recovered
13	51	M	Splenectomy	Restricted movement left diaph.	Left subcostal extraperitoneal	Left subphrenic	Died
14	27	M	Splenectomy	Limitation diaph. Elevated diaph.	Retroperitoneal through bed of 12th rib	Left subphrenic	Recovered
15	64	M	Small bowel resection	Large air-fluid level on right	Right subcostal extraperitoneal	Right subphrenic	Recovered
16	72	M	Colon resection	Elevated diaph. Air-bubble Barium enema leak	Left subcostal extraperitoneal	Left subphrenic	Recovered
17	49	M	Common duct exploration	Extravasation of dye from T tube cholangiogram	Rt. subcostal extraperitoneal	Right posterior subhepatic	Recovered
18	71	M	Ruptured gall bladder	Distended gall bladder	Rt. subcostal extraperitoneal	Right anterior subhepatic	Recovered
19	78	M	Perinephric abscess	Elevated diaph. Air-fluid level Limitation diaph. Pleural reaction	Retroperitoneal through bed of 12th rib	Right posterior subhepatic	Recovered

subphrenic space, Boyd has described four anatomic spaces and acknowledges six subphrenic abscesses.[7] This classification will be adhered to in the description of the cases reported in this series.

On the right Boyd recognizes one subphrenic suprahepatic space and one subhepatic space. On the left side he describes one combined subphrenic and subhepatic space and one further subhepatic space in the lesser sac. These spaces may be divided by pyogenic membranes into anterior and posterior subphrenic, and anterior and posterior subhepatic abscess on the right (Fig. 1). The abscesses on the left are limited to two descriptive locations: those which are subphrenic and involve the superior and/or inferior surfaces of the left lobe of the liver, and those within the lesser sac (Fig. 2). This simplified classification is of great help to the surgeon in locating and surgically approaching the subphrenic abscess he may encounter.

Cases in Present Series

During the past five years, a total of nineteen cases of subphrenic abscesses have been treated on the surgical service of this hospital (Table I). The age range was nine months to seventy-eight years with an average age of 49.9 years. Fifteen males and four females are included in the series. The original lesions causing the suppurative processes were all within the abdomen and are of considerable variety. Four cases followed splenectomy, four were related to rupture of the appendix, three were subsequent to perforation of peptic ulcer, and three were attributed to leakage from the duodenal stump following gastrectomy. One case followed a small bowel resection for closed loop obstruction and one case followed a left colon resection and demonstrated, by barium enema, a leak at the site of anastomosis. One case was attributed to rupture of the gall bladder and one case followed a common duct exploration. One case resulted from extension of a perinephric abscess on the right.

Diagnosis

Diagnosis was made within a period varying from one day to five weeks from the onset of the original lesion. All cases demonstrated fever and leukocytosis. An important diagnostic criterion was persistent localized tenderness over the involved area and particularly localized tenderness over the twelfth rib in cases with right posterior subhepatic abscesses.

Roentgenological examinations were employed as a diagnostic aid in all but one of the nineteen cases cited. Of the eighteen patients examined by this means, sixteen had diagnostically significant findings to suggest or confirm a subphrenic abscess. Six cases

demonstrated elevation and immobility of the diaphragm (Fig. 3). Although the presence of an elevated diaphragm should arouse strong suspicion of subphrenic abscess, it is far from pathognomonic.

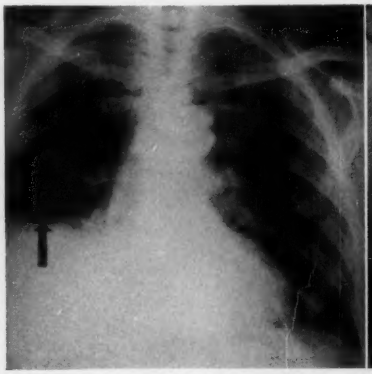


Fig. 3. Elevation of the right leaf of the diaphragm with pleural reaction. Case 10.

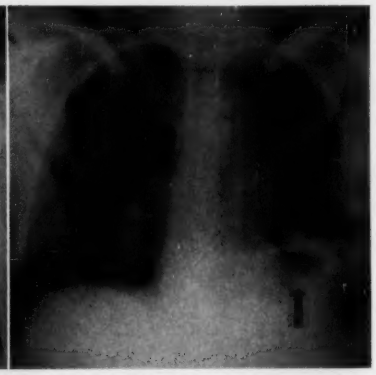


Fig. 4. Air bubble in a left subphrenic abscess with elevation of the diaphragm. Case 3.



Fig. 5. Fluid-air level beneath left leaf of diaphragm. Barium swallow demonstrates stomach in relation to the subphrenic bubble. Case No. 12.



Fig. 6. Barium swallow demonstrates gastric fistula draining into left subphrenic abscess.

Phrenic nerve damage, pleurisy, and such pulmonary abnormalities as pneumonitis, infarction, or atelectasis may be responsible.

An air-fluid level beneath the diaphragm and outside the gastro-intestinal tract must be considered diagnostic of subphrenic abscess. Unfortunately, this reliable sign is found in less than half of the cases and its absence in no way excludes the diagnosis of the disease. A fluid level is more likely to be demonstrated on the left where the dense liver shadow does not obscure visualization (Fig. 4).[8] In the present series, gas was present in the abscess in nine of the nineteen cases (47.3 per cent). Other authors have reported this finding in from 15 to 30 per cent of their cases.[9-12]

Contrast media has been useful in the diagnosis of subphrenic abscess (Fig. 5). We have found it particularly helpful in four cases in this series. A barium swallow demonstrated a gastric fistula draining into a left subphrenic abscess that developed following splenectomy (Fig. 6). Another case revealed a barium leak from the site of a colon anastomosis which

drained into a left subphrenic abscess. A T-tube cholangiogram demonstrated a fistula leading to a right subhepatic abscess (Fig. 7) and a fourth case showed a subhepatic abscess when iodized oil was injected into a sinus tract following leakage from a duodenal stump.

Treatment

The necessity for surgical drainage in cases of subphrenic abscess has been emphasized by the statistics published by Faxon[3] and by Ochsner and Graves.[13] In draining the abscess, it is of utmost importance to

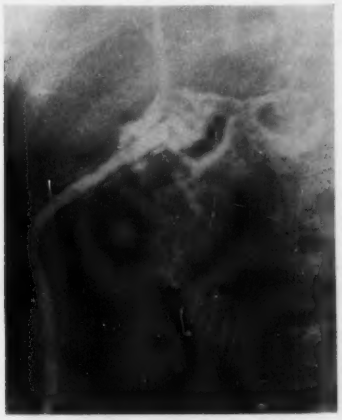


Fig. 7. T-tube cholangiogram demonstrates extravasation of dye from common duct into right subhepatic abscess. Case No. 16.

avoid contamination of uninvolved areas. The operative approach used in draining the subphrenic abscesses in this series has depended largely on the location of the abscess and this in turn has, in most cases, been related to the primary lesion causing the suppuration (Fig. 8). The accompanying chart lists the operative procedure employed in each case.

In applying the anterior extraserous approach an oblique incision is made 1 inch below and parallel with the costal margin, or through a previous subcostal incision. The incision is deepened through the skin, subcutaneous tissue, the three layers of flat anteriolateral abdominal muscles and the fascia transversalis lateral to the sheath of the rectus abdominis muscle. The sheath should not be opened in order to prevent its contamination with infected material. This incision exposes the extraperitoneal areolar tissue and the peritoneum.

To explore the subphrenic, suprahepatic space on either side, the finger is passed upward under the diaphragm and peels the peritoneum off of its undersurface (Fig. 8). This can be accomplished without difficulty, especially when inflammatory edema is present. When the abscess is reached in the subphrenic space, its wall is incised or opened bluntly by finger

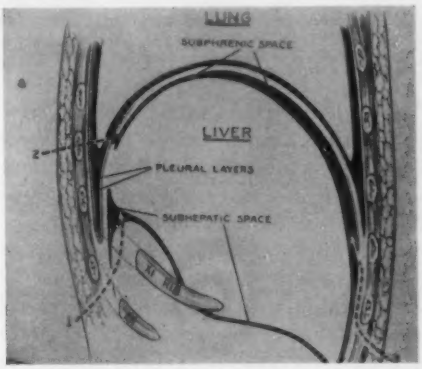


Fig. 8. The very large areas occupied by the subhepatic and subphrenic spaces on the right side are shown. The various approaches to these spaces are indicated: (1) Twelfth rib extraserous route (Ochsner), (2) Trendelenburg trans-pleural route, (3) Anterior extraserous approach. (Boyd, David: Surg. Clinics of North America, June, 1958, W. B. Saunders Company.)

pressure. The left anterior subhepatic space can easily be reached by pushing the finger backward and upward below the left lobe of the liver and above the stomach and lesser omentum. The right subhepatic space similarly can be reached by passing the finger upward and backward below the right lobe of the liver and above the hepatic flexure and right extremity of the transverse colon.

The posterior extraserous approach through the bed of the twelfth rib is accomplished by placing the skin incision over the course of the twelfth rib, starting about 1 inch from the midline and extending downward and forward to a point just beyond its tip. The incision should be long enough to accommodate the hand. The twelfth rib is exposed by dividing the skin and subcutaneous tissue, and the latissimus dorsi and serratus posterior inferior muscles. The periosteum over the whole length of the twelfth rib is divided and the periosteum separated from the upper and lower borders and deep surface of the rib. Care must be taken not to injure the pleura while doing this. The whole length of the rib is then excised subperiosteally.

The bed of the twelfth rib is then incised trans-

versely at the level of the spinous process of the first lumbar vertebra. At this point, an eighteen gauge needle may be inserted into the subphrenic space and aspiration carried out to identify the location of the abscess. Entrance into the abscess pocket may then be accomplished by incising over the course of the needle. The abscess is drained by a large rubber tube.

Mortality

There were two deaths in this series of nineteen patients (10.5 per cent). One of these occurred in a patient who had disruption of the duodenal stump following gastric resection. A huge abscess developed which filled both the right subhepatic and the left subphrenic space. He died in spite of drainage through an anterior subcostal incision. The other death was that of a patient who had suffered a ruptured spleen in an automobile accident. He was discharged from the hospital following recovery from splenectomy, but four weeks after operation was found to have a subphrenic abscess. The abscess was drained through a left subcostal incision and a Pezzar catheter was placed in the cavity. Gastric contents were noted to drain from the catheter and a subsequent barium swallow demonstrated a gastric fistula (Fig. 6). Feeding jejunostomy was performed, and at the time of this procedure extension of the abscess with multiple loculations was demonstrated. The patient eventually died and the autopsy revealed in addition to the gastric fistula, perforation of the left leaf of the diaphragm with a resulting empyema.

Conclusions

These cases emphasize that subphrenic abscess is a far from uncommon complication of intra-abdominal disease and surgery. Its diagnosis is aided by a strong index of suspicion when the postoperative patient is found to run an otherwise unexplained septic course. Localized subcostal tenderness anteriorly, and particularly twelfth rib tenderness posteriorly, are the most helpful physical findings. X-ray examination is invaluable in diagnosis and should include fluoroscopy for diaphragmatic motion as well as upright and decubitus films. Often the use of barium studies of the gastrointestinal tract and contrast media visualization of sinus tracts will be rewarding. Prompt surgical drainage when the diagnosis is made, rather than hopeful reliance on chemotherapy, is essential.

References

1. Ochsner, Alton: Surgical treatment of subphrenic infections. New Orleans Med. & S. J., 82:752, 1930.
2. Ochsner, Alton: Subphrenic abscess: An analysis of 3,372 collected and personal cases. Annals Surg., 98: 961, 1933.
3. Faxon, Henry H.: Subphrenic abscess: A report of one hundred and eleven consecutive operative cases. New England J. Med., 222:290, 1940.
4. Barlow, G. H.: Perforation of the stomach with obscure thoracic symptoms. London M. Gaz., 36:13, 1845.
5. Leyden: Ueber Pyopneumothorax Subphrenicus (und Subphreniche Abscesse), Ztschr. klin. Med., 1:320, 1879.
6. Barnard, H. L.: An address on surgical aspects of subphrenic abscess. Brit. M. J., 1:371, 1908.
7. Boyd, David P.: The anatomy and pathology of the subphrenic spaces. Surg. Clin. North America, 38:619, 1958.
8. Wise, Robert E., and Salzinan, Ferdinand A.: Roentgenologic diagnosis of sub-diaphragmatic Abscess. Surg. Clinics North America, 37:633, 1957.
9. Delario, A. J.: Sub-diaphragmatic abscess. Am. J. Roentgenol., 31:177, 1934.
10. Ochsner, Alton, and DeBakey, Michael: Subphrenic abscess. Surg. Gynec. & Obst., 66:426, 1938.
11. Elsberg, C. A.: A contribution to the pathology, diagnosis and treatment of subphrenic abscesses after appendicitis. Ann. Surg., 24:729, 1909.
12. Berman, J. K.: Subphrenic abscess. J. Indiana M. A., 18:217, 1925.
13. Ochsner, Alton, and Graves, Amos M.: Subphrenic abscess. Ann. Surg., 98:961, 1933.

Retinal Detachment

J. Reimer Wolter, M.D., Assistant Professor of Ophthalmology, University of Michigan Medical Center, reports about 70 per cent of success in corrective surgery for retinal detachment, separation of the retinal membrane from its adjoining tissues. It results from a break in the retinal membrane which causes fluids of the inner eye to escape between the adjacent membranes. The image surface is then distorted. The retina degenerates from lack of nourishment, and blindness results. The break must be sealed and fluids drained from between the membranes.

Doctor Wolter describes this operation as a delicate form of spot welding. Using electricity and diathermy needles, the break in the retina is sealed with scar tissue. The operation must be performed soon after the defect is detected, however, in order to restore vision.

Retinal detachment usually occurs in old age, or in patients with extreme near-sightedness. Sometimes it results from a blow to the eye.

Acute Erythrophagocytic Hemolytic Anemia

Treated by Replacement Transfusion

Paul S. Rutherford, M.D.
Kalamazoo, Michigan

THE SYMPTOMS of acute fulminating hemolytic anemia may be so severe that replacement of the patient's blood with normal blood is indicated as a lifesaving measure. Ordinary transfusions may fail to halt the acute hemolytic process and may not appreciably increase the oxygen-carrying capacity of the blood. Ordinary transfusions can be given only in limited number without the risk of circulatory overload. Replacement transfusion clears the circulation of excess free hemoglobin and might be expected to alleviate the danger of acute renal failure.[1]

Case Report

A well-nourished, three and one-half-year-old white boy (blood group B, Rh-positive) entered the hospital in an acutely ill state. He was pale, severely jaundiced, and semicomatose. His rectal temperature was 104 F., pulse 160, respirations 50 per minute. This illness had begun two days previously, with chills, fever and some vomiting. On the day before admission follicular tonsillitis was diagnosed and ilotycin (Eli Lilly & Co.) was started by mouth at 9:00 A.M. His mother noted a red-brown urine on this day and attributed it to the medicine. The patient complained of aching in his head, arms, legs and stomach. On the morning of hospital admission he had a large, chocolate-colored stool.

There was no family history of anemia or jaundice. The patient was the first of two children; his eighteen-month-old brother was healthy. The patient's past health was good; as a baby he had had slight eczema which seemed to be aggravated by ingestion of pork or veal; after the age of one year his skin had remained clear. He had received the usual immunizations against infectious diseases. Four months before his present illness he had received a short course of aureomycin for the treatment of tonsillitis.

On admission he had cloudiness of the sensorium. Examination revealed enlarged tonsils without definite follicles or bleeding points, lungs clear and some tenderness over the liver but neither liver nor spleen was enlarged. A medical consultant at this time reported that in a space of two or three days the child's condition had deteriorated from apparent good health to a highly critical state.

Laboratory findings on admission were as follows: erythrocytes 1,420,000; hemoglobin 3.5 gm. per 100 ml.; platelets normal in number; leukocytes 28,050 with 2 per cent metamyelocytes, 11 per cent band neutrophils, 66 per cent segmented neutrophils and 21 per cent lymphocytes; there were 2 nucleated red cells per 100 leukocytes; many band and segmented neutrophils contained phagocytized erythrocytes in all stages of destruction—some phagocytized erythrocytes were intact within leukocytes while others were represented by large, rounded, clear vacuoles within leukocytes (Figs. 1 and 2). Many erythrocytes appeared spherocytic. The red cell fragility was increased, with hemolysis beginning at 0.50 per cent Na Cl and complete at 0.36 per cent NaCl. In a simultaneous normal control, hemolysis began at 0.44 per cent NaCl and was complete at 0.30 per cent NaCl. The direct Coombs test was negative. Bone marrow aspirated from the tibia revealed granulocytic and erythrocytic hyperplasia; the erythrophagocytosis found in the marrow smears was similar to that in the peripheral blood except that some monocytes (as well as granulocytes) contained ingested erythrocytes. Culture of the bone marrow was negative for bacteria. The total serum bilirubin was 6.7 mg., of which only 0.7 mg. was direct-reacting. The red-brown urine contained hemoglobin and occasional erythrocytes, also a trace of albumin and many granular and hyaline casts.

The patient received 500 ml. of group B, Rh-positive blood on the morning of admission. He was also given 50 mg. of cortisone and 10 mg. of ACTH on this day and several times daily during most of his hospital stay. A second blood transfusion of 300 ml. was given the afternoon of the first hospital day. On the second day the patient's condition was markedly deteriorated. He was whimpering and failed to respond to verbal stimuli. Respiration was shallow and the pulse weak and thready. Hemoglobin was 4.5 gm. per 100 ml.; erythrocytes 1,860,000; leukocytes 28,150; erythrophagocytosis was again evident in the peripheral blood smear. A blood transfusion, begun at 11:30 A.M., was continued by very slow drip until a cut-down venesection was made at 3:00 P.M. During a five-hour period from 3 to 8 P.M., 900 ml. of blood was removed

Department of Pathology, Borgess Hospital, Kalamazoo.

THE AUTHOR

Paul S. Rutherford, M.D.



from an ankle vein while 900 ml. of donor blood was given into a vein of the opposite ankle. During most of this time the blood pressure and pulse improved, but the procedure was discontinued at 8 P.M. because the pulse rate had risen from 160 to 200 per minute and the beat had become almost imperceptible. During the replacement transfusion, 10 ml. of 10 per cent calcium gluconate was given intravenously and an additional 5 ml. was given at the termination of the procedure.

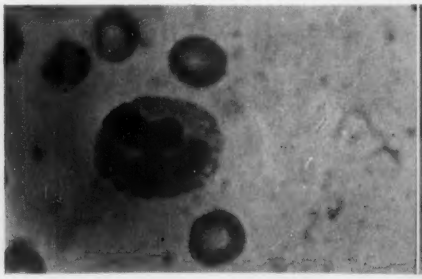


Fig. 1. Intact phagocytized erythrocyte within segmented neutrophil.

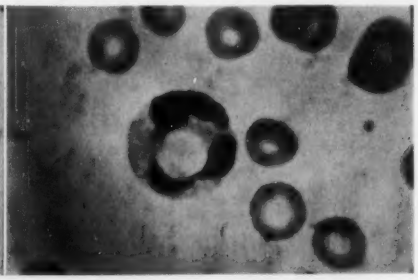


Fig. 2. Vacuolar, degenerated erythrocyte within segmented neutrophil.

The patient was definitely improved on the morning of the third day. Hemoglobin was 12 gm. per 100 ml.; erythrocytes 4,100,000; leukocytes 36,000 without evidence of erythrophagocytosis. Erythrophagocytosis was not found in any subsequent blood smears. The patient continued to improve and on the fourth day his total serum bilirubin had dropped to 4.6 mg. On the tenth day hemoglobin was 11 gm. per 100 ml.; erythrocytes 3,720,000; leukocytes 15,400. The patient was discharged on the twelfth hospital day. He returned to the laboratory 5 days later, at which time his hemoglobin concentration was 12.5 gm. per 100 ml.; leukocytes 9,200 with a normal differential count; total serum bilirubin 0.7 mg.; Coombs test negative; red cell fragility normal. The urine was light yellow in color and negative for albumin. A month later the patient remained in good health.

Discussion

Erythrophagocytosis by granulocytes appeared to be the mechanism of hemolysis in this case. This mechanism continued after transfusion of 800 ml. of blood but was arrested after a partial replacement transfusion, indicating that the factors responsible, whether in the red cells, plasma or leukocytes, were potent and continued to act until their removal and dilution. The increased fragility of the red cells during the acute hemolytic episode would suggest a red cell factor but the negative Coombs test affords some evidence against this. It seems likely that a plasma factor may have acted on red cells to make them unstable and may also have increased the phagocytic activity of the granulocytes. Rowley,[2] in 1908, reported a fatal case of erythrophagocytic anemia and estimated that, if all the leukocytes were equally erythrophagocytic all the red cells in the body could be destroyed within 2 hours. Lederer[3,4] described patients with acute acquired hemolytic anemia in 1925 and 1930; he attributed the anemia to infection and did not mention erythrophagocytosis. Hargraves, Herrell and Pearman[5] described a patient with erythrophagocytic anemia in 1941; their patient received daily blood transfusions until the hemoglobin level returned to normal and this patient became cured.

Summary and Conclusions

In a patient with erythrophagocytic hemolytic anemia, partial blood replacement stopped the hemolysis and erythrophagocytosis after ordinary blood transfusions had failed to do so.

It is suggested that erythrophagocytosis should be searched for in patients with acute hemolytic anemia. Replacement blood transfusion may be curative in anemias of this type which fail to respond to ordinary transfusion.

References

1. Rutherford, P. S.: Hemolytic blood transfusion reaction treated by replacement transfusion. Am. J. Clin. Path., 23:1059, 1953.
2. Rowley, M. W.: A fatal anemia with enormous numbers of circulating phagocytes. J. Exper. Med., 10:78, 1908.
3. Lederer, M.: A form of acute hemolytic anemia, probably of infectious origin. Am. J. M. Soc., 170:500, 1925.
4. Lederer, M.: Three additional cases of acute hemolytic (infectious) anemia. Am. J. M. Soc., 179:228, 1930.
5. Hargraves, M. M., Herrell, W. E., and Pearman, R. O.: Erythrophagocytic anemia (Lederer's anemia?): Report of a case with recovery. Proc. Staff. Meet., Mayo Clinic, 16:107, 1941.

1521 Gull Road

Poloxalkol in the Treatment of Constipation in Children

James A. Dugger, M.D.
Kalamazoo, Michigan

DETERGENT emulsifying agents, also known as surfactants or wetting agents, initiated a new approach to the treatment of constipation and solved many of the problems brought about by side effects incident to most bowel management regimens. Studies of this group of medicaments have mostly been made with dioctyl sodium sulfosuccinate. Its successful use in the treatment of constipation has been reported by a number of authors with an accumulated experience of approximately fifteen years.[1-6] Thus far it has been shown to be essentially free of side effects and toxicity. Amounts equal to 50 to 100 times the usual dose were employed in the treatment of some chronic intestinal disorders without the occurrence of adverse effects. In nutritional studies with dioctyl sodium sulfosuccinate, no effect on the absorption of proteins, fats, or vitamins was demonstrated. However, this agent is unsatisfactory in liquid form. Secondary to its cationic nature, it has a bitter taste, which is hard to mask. Poloxalkol, a new surfactant, is much more satisfactory because it is non-ionic, virtually tasteless, and acceptable to children who must take liquid medicine.

Poloxalkol, like dioctyl sodium sulfosuccinate, aids emulsification and prevents water loss from the fecal mass. This results in a soft, formed stool which is easily passed. Poloxakol is not an oil, a gel, or a bulk producer; and it does not stimulate peristalsis.

Its toxicity is extremely low according to data from animal toxicity studies and from clinical trials in human beings.[7] Available evidence suggests that it is as safe as dioctyl sodium sulfosuccinate.

Materials and Methods

Twenty-three patients aged two months to thirteen years were treated for constipation with a solution of poloxalkol containing 200 mg. per cc. supplied as Polykol Drops®. No effort was made to select the cases. All patients with constipation who presented themselves in my private pediatric practice were included in this study, except for three patients treated with poloxalkol capsules. In most of the children the constipation was idiopathic, in three it was secondary to fissure-in-ano, in two secondary to oral iron therapy, and in one there was a lack of reflex activity sufficient to empty the rectum. Symptoms had been present from one week to ten years and in most cases had been present for several months.

All pediatric age groups were well represented. Ten patients were between the ages of two and twelve months, ten between the ages of two and five years, and six between the ages of five and one-half and thirteen years.

The dosage of poloxalkol ranged from 0.25 cc. twice a day to 2 cc. three times a day. Most frequently patients received 1 cc. t.i.d., and the individual dose was usually given just before a meal. The drops were sometimes mixed with the formula or other foods, but most often were dropped directly into the patient's mouth. With one exception, the medication was given in divided doses.

Results

There were good results in twenty-one courses of treatment in twenty-three patients, fair results in two, and poor results in four (Table I). Of the patients with a fair response two were found to do better when given a peristaltic stimulator, although one of these benefited from the stool softening effect of poloxalkol to the extent that less laxative was required than previously.

The dosage was probably inadequate in two of the four failures: one patient received 0.25 cc. b.i.d.

THE AUTHOR
James A. Dugger, M.D.



This study was supported by a grant from The Upjohn Company; the poloxalkol was supplied as Polykol Drops.®

and the other 0.5 cc. b.i.d. The third patient with a poor response received 2 cc. t.i.d. without effect but did well on larger doses of poloxalkol in capsule form. The other failure was one of acceptance—the patient refused the medication.

TABLE I. RESULTS OF TREATMENT OF CONSTIPATION WITH A SOLUTION OF POLOXALKOL[1]

Daily Dose	Number Patients	Results		
		Good	Fair	Poor
0.5 cc.	1	0	0	1
1.0 cc.	2	1	0	1
1.5 cc.	4	4	0	0
2.0 cc.	4	4	0	0
3.0 cc.	15	12	2	1
6.0 cc.	1	0	0	1
Totals	27	21	2	4

[1]Four patients took two courses.

Side effects were noted in only one patient, who experienced cramps while he was taking 1 cc. three times a day. His mother reduced the dose to 1 cc. twice a day with relief of all symptoms and continued control of the constipation.

Case Reports

T.H., a six-month-old girl with a severe fissure-in-ano of several months duration, experienced considerable pain with each bowel movement. She had two to three hard stools daily. Between stools she complained of abdominal cramps and often vomited. Attempts to correct the constipation by dietary management failed; moreover, the use of sugars to soften the stool increased the abdominal cramps. She was given 0.5 cc. of the poloxalkol solution three times a day before meals for a period of three months. About two days after beginning treatment, her stools became normal. The fissure also healed rapidly without other treatment.

K.N., a two and one-half-year-old boy, had idiopathic constipation of more than two months duration. His stools were hard and difficult to pass. The mother said he often went two to three days without a bowel movement and sometimes required three enemas. Abdominal cramps were frequent between bowel movements. Management with a mineral oil emulsion had produced only moderate improvement. He was given 1 cc. of poloxalkol solution three times a day before meals. The day after this therapy was instituted his stools developed a normal, soft consistency. Treatment was continued for a month without side effects. The mother was most impressed by the assumption of a spontaneous daily pattern of defecation, which had not occurred with other management. It is of interest to note that while on poloxalkol this patient's cramps were relieved, whereas on the mineral oil emulsion he continued to have cramps even though his stool was softened.

J.M., a two-year-old girl, had been constipated for fifteen months. She was usually allowed to go for two days without defacation and then was given various medications. Although blood was sometimes seen in the stool, there was no fissure-in-ano. She was given 1 cc. poloxalkol solution three times a day before meals. Within four days the mother noticed that the stools had become perfectly normal and that bowel movements were spontaneous. No other medication was required and no side effects were observed.

T.S.K., an eight-month-old girl, had iron deficiency anemia and constipation secondary to an oral iron preparation. Mineral oil emulsion, prune juice, and dietary management had not helped the constipation. The patient was given 0.5 cc. poloxalkol solution three times a day before meals and within two days she began to have three spontaneous normal stools daily. One-half cc. t.i.d. proved to be too large a dose when foods with a natural laxative effect were given, and the mother adjusted the dose from two to three times a day depending on foods eaten and other factors such as the administration of antibiotics for upper respiratory infections. Treatment was continued for three months during which time no other bowel management was necessary and no side effects were noted.

Discussion

In the introductory paragraphs the taste of poloxalkol was stressed. Taste is particularly important in young children and infants because it governs acceptance or refusal of medication. Only two patients in this study objected to the taste of the solution of poloxalkol used. A five-year-old child would not take it, and a two-year-old objected at first but later accepted it. Initially, then, the solution was accepted by twenty-one of twenty-three children and subsequently accepted by twenty-two. One little girl (age four) liked it so much that she asked for each dose, and was instrumental in helping her mother to remember to give the medication regularly.

The presenting part of the fecal mass is ordinarily drier and harder than the remainder. Considering this fact I felt that maximum benefit could be obtained from surfactants present in the portion of each food bolus which would first reach the large bowel. Therefore, parents were advised to give poloxalkol immediately before meals.

References

1. Wilson, James L., and Dickinson, David G.: Use of dioctyl sodium sulfosuccinate (Aerosol O. T.) for severe constipation. J.A.M.A., 158:261, 1955.
2. Antos, Robert J.: A new approach to the treatment of severe constipation. Southwestern Med., 37:236 (Apr.) 1956.
3. Spiesman, Manual G., and Malow, Louis: New fecal softener (Doxinate) in the treatment of constipation. J. Lancet, 76:164, 1956.
4. Friedman, Marion: Dioctyl sodium sulfosuccinate (Doxinate) in chronic functional constipation. Am. Pract. & Dig. Treat., 7:1588, 1956.
5. Tevetoglu, Fethi: Pediatric use of dioctyl sodium sulfosuccinate. J. Pediat., 50:304, 1957.
6. Cass, Leo J., and Frederik, Willem S.: Doxinate in the treatment of constipation. Am. J. Gastroenterol., 26:691, 1956.
7. Personal Communication.
8. Dennison, Alfred D., Jr.: Use of dioctyl sodium sulfosuccinate in cardiovascular disease, correction of bowel function. Am. J. Cardiol., 1:400, 1958.

2901 S. Westnedge Avenue

Perforated Peptic Ulcer in the Elderly Patient

Franklin H. Cox, M.D.
Ulrich Moeser, M.D.
Kalamazoo, Michigan

PERFORATION of the stomach or duodenum is a common and well recognized complication of peptic ulcer. Its sudden onset, severe pain and board-like abdominal rigidity constitute a commanding clinical entity requiring immediate surgical attention. With these signs and symptoms in a young or middle-aged individual, in most instances confirmed by free air under the diaphragm, correct diagnosis and subsequent treatment are quickly initiated.

However, peritonitis in the older patient, whether chemical or bacterial, does not always present such a characteristic catastrophic picture. Furthermore, we can no longer be assured that perforation of an ulcer rarely occurs after the age of fifty.[1] The rising incidence of peptic ulcer and its complications in the aged is a reflection of our increasing geriatric population.

The purpose of this study is to analyze those cases of perforated peptic ulcer, both living and dead, admitted to Borgess Hospital since January 1, 1958. Emphasis will be placed on those particular diagnostic problems encountered in the older age group.

Twenty-three patients, whose diagnosis of perforated peptic ulcer was confirmed either by surgery or at autopsy, form the basis of this study. Their ages according to decade are summarized in Table I.

In this series there were eleven deaths, eight occurring in patients over sixty. Of these eleven patients six were previously diagnosed and treated as having peptic ulcer. Of the twelve remaining successfully treated and living patients, seven had previous therapy for peptic ulceration.

In all except two of the living patients a correct admitting diagnosis of perforated ulcer was made. By contrast, none of the dead patients were diagnosed on admission as having a perforated viscus. Subsequently in the group of eleven deaths only two patients were finally brought to surgery with closure of the perforation completed.

It soon became apparent that the death of these patients was directly related to an inability to arrive at an early diagnosis. Abdominal pain, when present in patients over sixty, was usually not severe and often not localized to the epigastrium. Abdominal rigidity, while present in all of the patients with successful surgical closure, was conspicuously absent in six of the eleven deaths.

TABLE I.

Decade	Number of Patients
0-10	0
11-20	2 (none died)
21-30	1 (none died)
31-40	0
41-50	5 (2 died)
51-60	6 (1 died)
61-70	1 (1 died)
71-80	6 (5 died)
81-90	2 (2 died)

The majority of the patients in the series of eleven deaths were admitted with a history of recent nausea and vomiting, abdominal pain which was not severe, and signs of mild peritoneal irritation. These complaints were interpreted either as an exacerbation of a previous peptic ulcer (three patients), acute pancreatitis (one patient), cholecystitis (two patients), or bowel obstruction (one patient). In one patient, a forty-five-year old man, a perforated gastric ulcer ended a prolonged terminal phase of esophageal squamous cell carcinoma.

Laboratory findings can be misleading in the diagnosis of peritonitis in the aged. In four autopsied patients, all of whom were over sixty, the total leukocyte count did not exceed 8,050 per cu. mm. However, this apparently normal total white count was accompanied by either an increase in the percentage of neutrophils or a shift to the left in the Schilling index. None of the patients who were successfully treated had a leukocyte count of less than 9,500 per cu. mm.

In four of the autopsied patients, the perforation was secondary to a gastric ulcer, and in one a marginal ulcer; the remaining six patients who expired

From the Department of Pathology, Borgess Hospital, Kalamazoo, Michigan.

had a perforated duodenal ulcer. All of the surviving patients were surgically treated for a perforated duodenal ulcer.

Generalized peritonitis was present in every autopsied patient. None of these patients revealed any attempt toward spontaneous closure of their perforation by either omental or local tissue reaction. This would refute the argument for "conservative" medical treatment for perforated peptic ulcer in the aged patient. In fact, it would appear that an elderly patient has less opportunity for tissue healing and spontaneous closure than his younger counterpart.

Treatment in the surviving group consisted of simple closure in eleven, and in the twelfth patient an additional subtotal gastrectomy was performed. All of these patients had an uneventful recovery with one exception where a complicating subphrenic abscess occurred.

Discussion

Many authors have emphasized that peptic ulcer is not limited to youth or middle age.[2-7] Indeed Stafford et al[9] found that 35 per cent of the patients admitted to Los Angeles County General Hospital for treatment of peptic ulcer were over sixty years of age. One case in every four from their series presented a major complication requiring surgery.

With an increase in the geriatric population and their medical problems, it becomes necessary to revise our concepts of disease with reference to this age group. Corresponding to the increased incidence of peptic ulcer in the aged are its major complications: obstruction, hemorrhage, intractability of pain, and perforation.[9]

Most authors are in agreement that hemorrhage occurs more frequently than perforation after the age of sixty, and that bleeding may often be massive.[3-5,7] As opposed to hemorrhage, which presents similar clinical findings and diagnostic problems in all age groups, perforation and subsequent peritonitis do not elicit the same prompt and sustained inflammatory response in the aged patient. It would appear that elderly patients do not react to the pain of perforating peptic ulcer and peritonitis as do younger patients.[5] Similarly, the clinical signs of peritonitis are often not apparent in geriatric patients.

As a result, these patients will not seek medical care with the rapidity usually demanded of a perforated viscus. Finally, the attending physician in the absence of clinical signs and symptoms of peritonitis may not press for the etiology of his patient's upper gastrointestinal upset. All of these factors result in advanced peritonitis and a high mortality rate.

Summary

Perforation of peptic ulceration in the aged patient is attended by an extremely high mortality. Eight of nine patients over sixty years of age in our series died. The reason for this high mortality is best related to the milder and less dramatic signs and symptoms of perforation and peritonitis in the aged patient.

Bibliography

1. Bockus, H. L.: Gastroenterology. Vol. 1, p. 503, Philadelphia. W. B. Saunders Company, 1943.
2. Howell, T. H., and Piggot, A. P.: Morbid anatomy of old age. Geriatrics, 7:137, 1952.
3. Kiefer, E. D., and Mekell, D. M.: Peptic ulcer in the aged. J.A.M.A., 133:1055, 1947.
4. Lasher, E. P.: The course of peptic ulceration in elderly persons. Surgery, 23:501, 1948.
5. Mason, S. A.: Peptic ulcer in the aged. J. M. Soc., New Jersey, 56:542, 1959.
6. Muslow, F. W.: Peptic ulcer in the aged. Am. J. Digest. Dis., 8:112, 1941.
7. Rafsky, H. A., Weingarten, M., and Krieger, C. L.: Onset of peptic ulcer in the aged. J.A.M.A., 136:739, 1948.
8. Stafford, C. E., and Hinshaw, D. B.: Marginal peptic ulcer in elderly patients. California Med., 88:155, 1958.
9. Stafford, C. E., Joergenson, E. J., and Murray, G. C.: Complications of peptic ulcer in the aged. California Med., 84:92, 1956.

1521 Gull Road

Replacement of Vertebral Bodies by Bone Grafts

Six cases have been reported with photographs of relevant roentgenograms demonstrating destruction or extensive damage of cervical and lumbar vertebrae by infection, tumor, or trauma.

These cases illustrate the feasibility of direct surgical attack upon the diseased area with replacement of the diseased vertebral bodies by bone grafts. Collapse of the vertebral column was thus prevented, and more rapid and safe mobilization of the patients was achieved.

Demonstrated, too, is the advantage of direct biopsy to give accurate diagnosis in destructive lesions of the vertebral bodies.—J. R. Cantrell, M.D., and L. H. Riley, Jr., M.D., Baltimore Surgeon, April, 1960.

Periodic Fever in Private Practice

William D. Harrelson, M.D.
Kalamazoo, Michigan

FEVER is commonly seen as a manifestation of many diverse ailments, ranging from infections and toxic conditions to neoplastic and metabolic causes. The true etiology may be easily determined or may resist the most intensive investigations. Confusing the entire picture is the concept of psychogenic fever,[1-2] which may be a real entity or a convenient catch-all for any obscure febrile syndrome. One of the most interesting of the febrile entities is that of "periodic fever," variously called "Familial Periodic Disease,"[3] "Familial Mediterranean Fever,"[4] and "La Maladie Periodique,"[5] and broadened by Reimann[6] to include periodic abdominalgia, cyclic neutropenia, periodic arthralgia[7] and later periodic sialorrhea.[8]

I first became interested in periodic fever in 1950 when I was fortunate to see a patient with typical findings. These consisted of recurrent episodes of fever up to 104 degrees at intervals of from three to four weeks, and lasting from five to seven days, with muscle and joint pains and morbiliform rash, plus a history of similar episodes in a son and grandfather. Extensive clinical studies were done and a diagnosis of periodic fever made. This patient was subsequently restudied and reported by Bouroncle and Doan.[9] Although quite common in the Near East, where it is called "The Armenian Disease,"[10] periodic disease has not been common in the United States. Heller's most complete review[4] mentions seventy-four cases and reviews one hundred seventy-nine others collected from the literature. I was therefore a bit surprised to be able to see four cases of the periodic syndrome since beginning practice in Kalamazoo nine years ago. I wish to summarize these cases here, and discuss briefly the recent literature with emphasis on current ideas concerning etiology. For more extensive reviews of the subject the reader is referred to the excellent recent reviews by Heller[4] and Priest and Nixon.[24]

Case Reports

Case 1.—J. B., a thirty-four-year-old-man of French-English ancestry, was originally seen in 1953 with a history of at least twelve episodes of fever, abdominal pain, nausea and obstipation lasting up to several days. On repeated occasions a diagnosis of appendicitis was entertained because of the abdominal tenderness referred into the right lower quadrant, leukocytosis, and fever. However, the patient refused surgery because he knew the episode would go away spontaneously if he waited. Frequency varied from monthly to six months, with no spells for the past two years. System review was negative except for previous allergies of mild nature, and hepatitis while in the service. The patient's father has diabetes and also had similar episodes. Interestingly enough, the father's fever periods apparently lasted from the teens to the thirties and then ceased, a span of years similar to that of his son.

Repeated physical examinations during episodes have disclosed a sallow color, fever to 102 degrees, diffuse lower abdominal tenderness more prominent over MacBurney's point, and on one occasion the spleen was palpable three fingers below the left costal margin. Between episodes, the patient looked and felt entirely well.

Laboratory tests that were done included multiple agglutinations, fasting blood sugar, erythrocyte fragility tests, platelet counts, bromsulfalein liver function test, serum bilirubin, serum proteins with A/G ratio, metabolism tests, multiple stool examinations and urinalyses. Blood counts between episodes were normal.

Complete gastro-intestinal x-rays were normal, as was an intravenous pyelogram.

There have been no attempts at therapy, since there have been no recent episodes, but the patient is ready to try Medrol® should the disease recur.

Case 2.—E. M., a twenty-eight-year-old housewife of Scotch-Irish ancestry with a three year history of recurrent joint pains, had fever as high as 103 degrees and headache. Episodes began in January, 1957, with pain and swelling in the left knee and fever to 103 degrees. She was felt to have infectious arthritis when urine cultures disclosed staphylococci and streptococci, but urinalysis was otherwise negative and films of the kidneys were negative. Other studies done included antistreptolysin titers, L.E. cell test, C-reactive protein and complete blood counts plus x-rays of the knees. All of these were normal. Treatment was begun with Gantrisin® and the fever and aches in the knees disappeared. Recurrences of the above nature took place at approximately monthly intervals subsequently, but ceased when the patient became pregnant, and did not recur until six months following her delivery. I saw the patient at this time when she gave a history of being ill for five days with pain in the right foot below the ankle, then in the kneecaps, with chills

THE AUTHOR

William D. Harrelson, M.D.



and fever to 103 degrees. She also had a severe headache, with symptoms helped to some extent by aspirin and Anacin.® Past history disclosed the usual childhood diseases plus urinary tract infection at age twelve or thirteen and recurrent mild anemia. There was no history of drug allergies or other allergic state, and nothing to suggest easy bruising of the skin. Family history was not helpful, being specifically negative for allergies or episodes similar to those described by the patient.

Complete physical examination disclosed some tenderness about the medial meniscus of the left knee and there was question of increased fluid in both knee joints. The right foot was completely negative. Remainder of the examination disclosed only a grade I apical substernal short blowing murmur previously described and felt functional, plus a few small lymph nodes in the left neck.

No extensive laboratory studies were done since the above-mentioned examinations had been unrevealing. Repeat urinalyses, however, were negative. Urinary 17-ketosteroid excretion was 6.9 mgm. in twenty-four hours during an episode of fever, rising to 39.6 mgm. in twenty-four hours following the administration of 40 units of zinc ACTH. Urinary gonadotrophins were 12 M.U. per day, and estrogen excretion 2.6 gamma (R.U.) per day. Serum electrophoresis disclosed normal results.

Since being under my care, the patient has had approximately six episodes of fever, headache and joint pains. Antibiotics were not used since they had been previously tried without benefit. Analgesics and tranquilizers were used but were not effective and finally Medrol® therapy was instituted. Relief on 16 mgm. daily of this drug has been dramatic, with freedom from episodes as long as three months. Another recent severe episode lasting six days has been promptly relieved by Medrol.® The patient's general health remains excellent.

Case 3.—M. I., a thirty-three-year-old housewife, has been having episodes of fever, chills, headache and generalized malaise with prostration for the past four years. Recurrences are irregular, from every week to every month and last two to three days with fever as high as 99.6 degrees. She has had many treatments with antibiotics, with some benefit apparently from Aureomycin.® Episodes ceased in this patient also when pregnant, and on one occasion she went three months without symptoms. In June, 1956, she was hospitalized and extensive tests were done but were all negative. These included agglutinations for typhoid, paratyphoid and brucella, plus complete gastrointestinal x-rays, intravenous pyelograms and sinus films. A mild elevation of the sedimentation rate and hypothroidism were the only subsequent findings on repeated testings, including multiple blood counts and urinalyses.

I saw the patient first in January, 1959, at which time the history was as presented above. She also had symptoms suggesting premenstrual tension, recurrent mild anxiety and hypothyroidism. Family history was unrewarding since the patient is adopted. On examination the only positive findings were small, rubbery, discrete nodes in the post-cerival areas and at the angles of the jaws. These had been previously described in 1958 and were essentially unchanged. Spleen was not enlarged and no axillary or inguinal nodes were palpable. A transient, variable aortic and mitral systolic blowing murmur was heard and felt to be functional in origin. Proctoscopic and pelvic examinations were also normal.

Repeat blood count disclosed a sedimentation rate of 22 mm. per hour. BMR minus 12 per cent. Other studies yielding normal results were antistreptolysin titer, L. E. cell test, agglutinations for brucella, typhoid and paratyphoid, three stools for ova and parasites, electrocardiogram, 17-ketosteroid excretion, serum proteins, gall bladder and chest x-rays. An otolaryngologist found no evidence of sinus infection or disease in the ears, nose or throat.

The patient's health has remained stable except for another miscarriage and a recent severe episode lasting two weeks and coming on following a bout of influenza.

Case 4.—J. B., is a thirty-four-year-old male executive, whose illness has been followed for the past three years. Symptoms have been present for five years and consist of approximately monthly episodes of fever up to 102 degrees, lasting from four to twenty-four hours. There is fatigue and aching and malaise when he has the fever and following the episode he will be tired but then will feel entirely well until another episode occurs. About one year after the onset of his symptoms a malarial smear was obtained which was reported as showing malarial parasites. He was treated with quinine which was successful as long as he took it, but the fever episodes would recur when he stopped the quinine. Patient has never been out of the continental United States but has been in Florida and Texas for short periods. Multiple thick film preparations were negative for malarial parasites during febrile episodes, but in spite of this he was placed on Pamaquin therapy without effect. Spleen has never been palpable but the liver edge has been felt on several occasions, once as far down as three fingers. Patient has no known allergies. There are no particular headaches when he is ill or at other times. He does think that excessive fatigue or drinking or stress may precipitate an episode. Several complete physical examinations have revealed nothing other than the mentioned mild hepatomegaly, and on one occasion during a febrile episode exudative tonsillitis was noted. Because of this he underwent tonsillectomy, without effect upon his febrile episodes. White count has been found to be consistently elevated, from 11,500 to 20,000. Because of concern about the episodes, the patient was seen at the Cleveland Clinic in 1958. At this time general examination was negative again except for the palpable liver edge. Leukocytosis of 13,500 with 65 per cent neutrophils was again noted. Multiple agglutinations and skin tests plus malarial smear, cephalin flocculation test, and L.E. cell tests were all negative. Blood urea nitrogen was elevated to 37 mg. per cent. Chest and kidney x-rays were normal as was the small bowel and colon and terminal ilium. These consultants did not feel that the patient had any chronic internal infection as the cause of his symptoms and speculated about the possibility of diencephalic discharge or atypical migraine to account for the episodes.

Other studies done have included sinus films and total serum proteins with A/G ratio, which were grossly normal. Serum electrophoresis disclosed slight elevation of the Beta globulin fraction to 18 per cent. 17-ketosteroid excretion was 23 mgm. in a twenty-four-hour sample of urine.

Since the explanation of the nature of these episodes, the patient has been much relieved and they seem less severe. He does not wish to try steroids or sedatives since he knows that the fever will go away shortly if he just waits. His general health remains excellent.

Discussion

The basic cause of the illness described as periodic fever has been debated for years, the explanation varying with the popular ideas of the time. This is well illustrated by Janeway's case[11] of 1908, which was probably the first clear-cut report of the condi-

tion. He speculated on infectious, "toxemic," migrainous and other central nervous system possibilities including neurosis, and concluded that "toxemic" causes were most likely the explanation. His patient was later seen by Cooke,[12] who felt he cured this same patient by removing milk from her diet and therefore felt the cause could be allergy. His thesis was supported by Rowe,[13] who reported another patient cured by a diet eliminating milk. He felt a localized or generalized allergy could affect the temperature regulating mechanism of the brain in such a way as to cause the recurrent episodes, or possibly through accumulation of specific reacting antibodies in the shock organs involved.

That chronic infection may confuse the issue is seen by the plethora of attempts made in almost all cases reported to find an infectious agent. The report of Allen[14] bears this out, since his patient was reported cured by tonsillectomy, only to be subsequently restudied by Wolf and Wolff[15] and felt to have febrile episodes due to unusual anxiety and tension acting on unstable thermoregulatory centers in the brain. Certainly the case reported by these authors has many similarities to Case 4 described above.

Other influences than emotion on the hypothalamus have been found to cause recurrent febrile episodes, usually with other associated hypothalamic findings. Aring and Engel[16] reviewed the physiologic, psychologic and anatomic aspects of the hypothalamic disturbances most completely and described a patient with reccurent hyperthermic episodes, plus changes in blood pressure, respiration, gastrointestinal motility and urinary output. These episodes could be precipitated by emotional influences. The studies of these authors confirmed and enlarged the work of Penfield,[17] who introduced the concept of "Diencephalic Autonomic Epilepsy" and described a patient with a ball valve tumor of the third ventricle. However, this patient had episodes of hypothermia, apparently due to involvement of a different area of the hypothalamus from the patient of Aring and Engel. Bauer,[18] in discussing hypothalamic hyperthermia, emphasized three characteristic findings: (1) absence of general malaise common with high temperatures of toxic origin; (2) coldness and clamminess of the extremities, and (3) unresponsiveness to salicylate and responsiveness to cerebral sedatives. He described the convulsions of hypothalamic origin as distinct, with no loss of consciousness, an aura of convulsive laughing or crying, decerebrate rigidity, extreme perspiration, very high pulse rate, low blood pressure, popping eyes and extreme fright. These findings are vastly different from the reported cases of "abdominal epilepsy,"[19-20] which have abdominal pain and hypermotility up to twenty-four hours in duration but no fever.

More recently, Bondy and associates[21] have suggested that etiocholanolone may be a possible cause of the recurrent febrile syndrome known as periodic fever. This suggestion followed the work of Kappas and associates,[22] who reported on the pyrogenic and inflammatory reaction produced by a substance (etiocholanolone) of physiologic origin from adrenal and gonadal tissue. This reaction was greatly lessened by pre-treatment with cortisone and the severity benefited by aspirin. The former authors reported elevation of free etiocholanolone in the plasma of two cases of periodic fever, but only during the febrile episodes. They felt that the liver might be intermittently unable to congugate the steroid with resulting elevated blood levels and clinical symptoms, and cited abnormalities in liver function, particularly altered A/G ratios as evidence.

The observation that periodic fever is often complicated by nephropathy,[5] and eventually amyloidosis,[23,24] led Tuqan[25] to review from a clinicopathologic viewpoint the extensive experience with the disease at the American University Hospital in Beirut, Lebanon. He found in tissues removed during acute episodes mild acute inflammation of a non-specific sort, with edema, congestion and infiltration with polymorphonuclear leukocytes and round cells. He found an absence of fibrin in the specimens and felt this was why granulations and intestinal obstruction did not develop. The fact that the edema fluid contained considerable protein was also felt of considerable importance. Tuqan also found two autopsied cases with amyloid deposits in kidneys, spleen and vessels of the liver. He felt the early glomerular lesions resembled the wire loops seen in disseminated lupus erythematosus. He was also convinced that amyloid was a precipitated antigen-antibody complex, citing the work of Mellors,[26] who used fluorescent techniques to demonstrate localized gamma globulin in the glomeruli in renal amyloidosis, glomerulonephritis and allied diseases. He concluded that from the anatomic, clinical and immunologic and chemical features demonstrated he felt collagen disease, amyloidosis and periodic fever are related entities and in fact periodic fever may be a collagen disease. Other interesting evidence is supplied by Eklund and Reimann,[27] who produced amyloidosis preceded by constant hyperglobulinemia in rabbits by repeated injections of sodium caseinate, and concluded that chronic hyperglobulinemia was an important factor

in the etiology of amyloidosis of the secondary type. Priest and Nixon[28] agreed with the above concept and stressed the conclusive work of DeVries[29] and associates. These workers used the electron microscope to describe abnormal red cell membranes in patients with the disease, and postulated that periodic fever was auto-immune disease developing on a constitutional basis of defective structure of the red cells. These latter concepts seem most convincing, although there are some features that are as yet unexplained, such as the reason for the intermittent nature of the spells, the remissions seen during pregnancy, and the occasional response to steroids, as dramatically demonstrated in Case 1 above and the patient of Bournocle.[9]

Heller[4] concluded that the abnormalities seen by DeVries and his co-workers were again merely manifestations of the disease and not really the etiology, and suggested that the basic metabolic error may prove to be a disturbance of porphyrin metabolism, as evidenced by elevated uroporphyrin levels found in twenty-five of their cases.

Conclusion

Certainly the question of etiology remains to some extent unsettled, and it is my belief that with further studies the diagnosis will be made on a more positive basis than by exclusion, with perhaps several subgroups emerging. It is also hoped that new therapy will be developed for those types not currently responding to steroids. That this may be already coming true is seen in the recent suggestion by Reimann[30] that fluoromethalone may prove to be of value in the treatment of periodic fever.

References

1. Falcon-Lesses, M., and Proger, S.: Psychogenic fever. New England J. Med., 203:1034, 1930.
2. Smith, D.: Fever of undetermined etiology. J. Michigan M. Soc., 38:125, 1939.
3. Editorial: Is familial periodic disease a nosological entity? J.A.M.A., 134:168, 1959.
4. Heller, H., Sohar, E., and Scherf, L.: Familial Mediterranean fever. Arch. Int. Med., 102:50, 1958.
5. Cattan, R., and Mamou, H.: 14 case de maladie periodique dont 8 compliques de nephropathies. Bull. et mém. Soc. méd. hôp. Paris, 67:1104, 1951.
6. Reimann, H.: Periodic disease. J.A.M.A., 141:175, 1949.
7. Reimann, H., and Angelides, A.: Periodic arthralgia in 23 members of 5 generations of a family. J.A.M.A., 146:713, 1951.
8. Reimann, H., and Lindquist, J.: Perdiodic sialorrhea. J.A.M.A., 149:1465, 1952.
9. Bouroncle, B., and Doan, C.: "Periodic fever;" occurrence in 5 generations. Am. J. Med., 23:502, 1957.
10. Reimann, H., Moadie, J., Semerdjian, S., and Sahyoun, P.: Periodic peritonitis: heredity and pathology; report of 72 cases. J.A.M.A., 154:1254, 1954.
11. Janeway, T., and Mosenthal, H.: An unusual paroxysmal syndrome, probably allied to recurrent vomiting, with a study of the nitrogen metabolism. Tr. A. Am. Physicians, 23:504, 1908.
12. Cooke, R.: Gastro-intestinal manifestations of allergy. Bull. New York Acad. Med., 9:15, 1933.
13. Rowe, A.: Fever due to food allergy. Ann. Allergy, 6:252, 1948.
14. Allen, E.: Intermittent hyperthermia of seven years duration. Ann. Int. Med., 10:1204, 1937.
15. Wolf, S., and Wolff, H.: Intermittent fever of unknown origin. Arch. Int. Med., 70:293, 1942.
16. Aring, C., and Engel, G.: Hypothalamic attacks with thalamic lesions: I. physiologic and psychologic considerations; II. anatomic considerations. Arch. Neurol. & Psychiat., 54:37 I; 54:44 II, 1945.
17. Penfield, W.: Diencephalic autonomic epilepsy. Arch. Neurol. & Psychiat., 22:358, 1929.
18. Bauer, H.: Endocrine and other clinical manifestations of hypothalamic disease. J. Clin. Endocrinol. & Metab., 14:13, 1954.
19. Moore, M.: Within the realm of epilepsy. J. Nerv. & Mental Dis., 116:841, 1952.
20. Moore, M.: Abdominal epilepsy. Rev. Gastroenterol., 15:381, 1948.
21. Bondy, P., Cohn, G., Hermann, W., and Crispell, K.: The possible relationship of etiocholanolone to periodic fever. Yale J. Biol. & Med., 30:395, 1958.
22. Kappas, A., Hellman, L., Fukushima, D., and Gallagher, T.: The pyrogenic effect of etiocholanolone. J. Clin. Endocrinol., 17:451, 1957.
23. Mamou, H., and Cattan, R.: La maladie periodique (sur 14 cas personnels dont 8 compliques de nephropathies). la Semaine hôp. Paris, 25:1062, 1952.
24. Alkalay, I., Shenfield, M., and Levy, E.: Familial periodic disease with renal damage. J.A.M.A., 170:653, 1959.
25. Tuqan, N.: Periodic disease: a clinicopathologic study. Ann. Int. Med., 49:885, 1958.
26. Mellors, R., and Ortega, L.: III. New observations of the pathogensis of glomerulonephritis, lipoid nephrosis, periarteritis nodosa and secondary amlyloidosis in man; localizing gamma globulins. Am. J. Path., 32:455, 1956.
27. Eklund, C., and Reimann, H.: Etiology of amyloid disease, with note on experimental renal amyloidosis. Arch. Path., 21:1, 1936.
28. Priest, R., and Nixon, R.: Familial recurring polyserositis: a disease entity. Ann. Int. Med., 51:1253, 1959.
29. DeVries, A., Danon, D., Nelken, D., and Henig, E.: Red cell abnormality and autoimmune antibody in periodic disease. Harefuah, 52:1, 1959.
30. Reimann, H.: Periodic disease. J.A.M.A., 171:857, 1959.

1324 S. Park Street

An Existential Approach to the Psychiatric Interview

W. R. Slenger, M.D.
Kalamazoo, Michigan

THIS COMMUNICATION will describe the use of the psychiatric consultation for brief therapy to change the disturbance of equilibrium in the patient by using the transaction between her and the physician. The disturbance of equilibrium will be described in the area of the identity problem, or problem of existence. Three patients will be cited, the third in greatest detail.

Before describing the clinical material, let me review several of the concepts that are utilized in which the collection of data is also part of the actual process of therapeutic intervention.

Concepts

I. Identity

I like to call *Identity*, the first of these concepts, the possession of a good-packaged feeling. As with a crustacean, or better, a turtle, the person is surrounded by armor-plate; we are surrounded by our integument. Our ego-boundaries are the limits where the "I" stops and the "not-me" begins. Intact ego-boundaries are crucial for knowing who-is-who in transactions with other human beings. The following semantic problem, seen in communication transactions, is a common indicator of a disturbance of these boundaries, the use of the pronoun "you" in referring to the self. Many non-neurotic people have this semantic habit, of course, because it is cultural. And some non-neurotic people do not have it. But all the people I see in consultation have it; it is part of their identity problem. We hear them talking as egos in the second person about themselves in a "not-me" sense.

Clinical Example A.—Please imagine the patient saying, "You know how it is if you hear the kids screaming for a couple of hours before supper and you are trying to get dinner and you don't know how you should feel and your husband comes in and he says, 'Why do you look so tired?' and you think why shouldn't you look tired and you would like to belt him and you say to him why shouldn't you look tired, you jerk." And I say to my patient, "Yes, you do look tired," and the patient says to me, "You sure do."

In this case we see that communication has substantially broken down. On the basis of language it is not clear who is complaining, who is listening, who is being talked about, or experiencing fatigue or criticizing, or who is tired: the girl, the husband, or the doctor.

II. Primary Process

A second concept is *Primary Process*. We know that in the earliest infant-mommie relationship the infant does not separate itself from the mother; as a matter of fact, the infant feels gloriously united when in contact, and complete only then; when mother goes away from the infant, baby has the profoundly disturbing feeling: "part of me has detached itself from me and has walked away." In other words, this is a sort of condensation; also, part can stand for the totality, and the infant feels, "if part of me is gone, I am all gone."

Deficiency in growth of a mature Ego allows persistence of these primary process problems; stress can create regression and allow them to surface. We frequently see this difficulty in differentiating between subject and object, or between the me and the not-me. It is helpful, early in treatment to focus some attention on this by stating: "When I talk about me, I understand myself better, and I

THE AUTHOR
W. R. Slenger, M.D.



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have a better awareness that I am myself, and I know better what my feelings are if I use the word I, not the word YOU. As people, we understand each other better if, when we are talking about ourselves, we use the first person 'I'." People gradually catch onto this after I have reminded them of what they are doing several dozen times in the first few sessions. It focuses attention on the self as being-in-the-world with realness. Why talk about primary process? I believe that an awareness of this helps us to view the over-all concept of identity; the efficiency of the functioning of an ego is largely determined by its control over primary process thinking and perception of itself as an individual, neither parasitic nor symbiotic in interpersonal relationships.

III. *Ego Boundary Diffusion*

The psychiatrist uses the term border-line condition frequently to describe those individuals who have a high level of primary process in their character structure. We see this come to a sharp focus in people who are terribly busy imagining what other people are imagining about them, and without cues from the other person, they proceed to react to that person on a basis of what has been imagined. This further leads to the confusing result that the imaginer is not certain whether his thoughts actually belong to himself or to the other person; it leads to all manner of difficulties in relationships.

Clinical Example B.—I am thinking of a young professional woman who works with psychiatric patients and wears a white uniform. For the first few sessions with me she was late, and we learned that this was due to her changing from her white uniform to her street clothes before coming to her session. When I mildly wondered if this was an unnecessary burden of formality, she stated that all day long in her white uniform she felt that it defined her role in working with psychiatric patients. Now she was worrying that if she wore the uniform to her session she would have difficulty in knowing if she were therapist or if I were; the uniform implied a role in the scene, and in playing her bit, it became herself, as therapist; to change her role it was necessary to change uniform. Further, she felt she should identify with me, but this carried with it the danger of loss of ego boundaries and feeling of selfness in thus failing to differentiate herself from myself and lead to a terror that she would get lost, at the interface, or point of contact with me. This getting-lost occurs in her relations with people if she does not stand aloof from them, and to help her, we proceed to examine the question of existence: what is her world? what is her self? Where does she begin and end and where does her world begin and end and where are her boundaries?

Clinical Example C.—The third example submitted is an orthopedic patient who had been in bed for five weeks during which period she had myelography and had been in traction-therapy for backache. This required considerable immobility and passivity, and further created a considerable feeling of helplessness which she had accepted with apparent success until forty-eight hours before I first saw her. She had become overwhelmed with panic to the extent that she and the staff were both certain that she had no control over herself: mind, emotions, bodily sensations or behavior. None of the medication given, and she had had much, covered the tremendous tension she was experiencing.

It was helpful initially to recognize with her that she was afraid of total loss of control of the self, and further noting that this had the more sweeping significance to her that she was insane. This excellent lady felt that she didn't have total control and therefore to her this meant no control.

Her usual technique to solve such a problem was two-fold: first, to put it out of mind: "I am not going to let myself think any unpleasant thoughts or experience any improper or unpleasant emotions, nor let unpleasant sensations bother me;" secondly, to tighten up all voluntary muscle and thus surround herself with a package of armor-plated muscular stiffness. Those two techniques resulted in a sort of total bracing, skeletal muscles and mental apparatus; the more frightened, the more bracing and so on, so that the problem-solving measures were creating the problem, and the greater the control applied, the more helpless she became. The situation worsened by the moment.

From an existential point of view, we can see that she was a being-in-the-world, it was her world, she was the most important person in it, and something had happened to it, so she was asked, "Tell me about your world." Obviously this is a very strange question, unconventional and surprising; and as she did not answer, it was repeated. She stated, "I work and take care of my children." This answer apparently had nothing to do with the presenting situation.

She then went on to describe the here and now: how uncomfortable she felt and how glad she was to see me and how she just knew that I was going to help her. Thus we see that she was describing her world as she saw it right now and also was informing me

that she had a strong belief in the magical power of hope, and that concentrating on this magic would somehow make things happen. She also was revealing that the physician was a highly over-estimated and over-evaluated omniscient and omnipotent personage. Furthermore, she was confusing knowing with hoping. She was therefore gently informed that neither of us could possibly know that I was going to help her, but that we could both hope that she would be able to tell me a lot about herself. This was important so that physician and patient would not jointly believe in magic. She was then asked, "Tell me all you can about your world." She stated, "Well, you know I'm a nurse and have no husband, and I take care of my children and work." She then drifted off to tell me about the sensations under her skin, her air-swallowing, urinary frequency, pain and tenderness in her joints, and pleaded with me to help her. I grinned and said that I was going to do the best I could but could she tell me more about her world. This was annoying her, which was revealed by a petulant question: why did I keep coming back to that? Didn't I know that she worked and took care of the kids? She was then asked, "What have you been doing for the past five weeks?" This was a surprise. She said, "I have been lying here." I then said tentatively, "it must have hurt your dignity." At this she burst into tears and said with great feeling, "What? Why should it?"

There are two things of interest in this outburst. First is transference: already we know that before seeing me she had had me endowed with a halo, of being all-knowing and all-powerful and this included the trapping of long buried infantile feeling toward her parents. Therefore, it was more than mere appropriate annoyance with me in the present situation, behaving as I was unexpectedly, and disappointing her anticipation of something heroic. Secondly, we notice her use of the word "should." This is another common semantic problem: this word probably meant an assortment of things, such as, "You are accusing me of being sensitive, when you ask if it hurt my dignity, and I shouldn't be sensitive, and if you remind me that I am, you are damaging an illusion of mine, namely, that I am strong and insensitive; and further, I don't want to know that my dignity has been hurt, and I don't want you to know it, and I prefer to pretend that it isn't, and if you suggest, or accuse me that it is hurt, does that mean that you know more about me than I know about me, and if so, are you criticizing me or are you telling me that my dignity should not be hurt; and finally, are you telling me that I am a sissy to let something hurt me?" All of this is involved with the word "should," when she said, "Why should it hurt my dignity?"

She was then informed, "I don't know that it should hurt your dignity, but I feel that it *has*." She answered, "Well, would you like to lie here like this and feel that nothing is being done?" She then continued with angry tears to tell me about the realistic suffering which she had experienced and this went on for about ten minutes. It covered a lot of different areas of suffering which involved loss of self esteem and her picture of herself as being helpless, to say nothing of the bodily discomfort, which we notice was increased by the defensive bracing. After a measure of this, she finally stopped, mopped the tears and smiled apologetically, expecting me to be as ashamed of her as she was of herself for having complained and wept.

I said tentatively, "It is difficult for you to cry?" And she poutingly said, "Why should you cry; you haven't anything to cry about." Let us note together the language here: the word "you" used for the self, and the word "should." We also observe the destructive attitude toward the feeling-self, the denial of self, and the denial of the reality situation which really was something to weep about. I waited for her to continue, she was silent, and I waited some more and she was silent some more, so I finally asked, "Tell me more about your world." She again was clearly petulant and yet seemed to be a little more familiar with the question, for with a touch of playfulness she said, "Oh, you are coming back to that again."

It was now felt that we had enough data and that it would be possible to feed back (like in an audio electronic set-up) what she had been saying about herself and her world: that she was a widow, a sole parent, a nurse, and that obviously she had not been her real self for the past five weeks, since she had been out-of-her-real-world. Then very slowly, for emphasis, and in the first person, she was informed, ". . . and when we feel that we are not ourselves and in our world, we do not feel real, and when we do not feel real we feel crazy." This was startling. Something changed.

Discussion

We also know, since she is a member of the healing profession, that her image of herself would include being superordinate and not being subordinate, in the helper-helpee interaction. She fancied herself as a helper, and not as a person who needed help. This

is a very delicate area, for involved, of course, is the matter of secondary gain. After all, when we are helpless there is some satisfaction in being cared for because we never outgrow that little tugging feeling from the past, reminding us of the pleasures of being babied.

In the case of excellent citizens like this worthy nurse, however, vast accounts of guilt attend such gratifications and temptations to enjoy being comforted must be handled in some way. Her way was to use the mechanism of denial, and it was fairly obvious that she was very angry with herself. This naturally would be reinforced if the staff implied in any way that she was making a baby out of herself and that she ought to have better control, and some measure of this had been communicated by her colleagues. We also see that deeply embedded in the characterologic matrix was a need to deny dependency yearnings, and to be very harsh with herself. Merely being a patient, she was in an extremely dangerous position for the self-esteem, and under this impact, identity was ebbing away: she was not her real self, and therefore not functionally real. Her home-world was absent; her occupation-world was reversed. All was sacrificed.

This is a kind of person on whom tranquilizing medication has a negative therapeutic effect. There is a fuzzy feeling, a loss of acuity and customary alertness, a diminished clarity of intergrated thinking and conceptualizing, a loss of awareness of the self, others, and relationships between the two, and there is a decrease in the effectiveness of customary controls. She was therefore informed that all medications except aspirin would be discontinued, and this was accompanied by the supporting statement that it was not imagined that she was the kind of person who wanted to depend on chemical help. Her confirmation of this was revealed in an emphatic statement that she liked to be in control of herself. She also stated that she was now more comfortable, but was apprehensive about the coming night. And we recognized together that the absence of people, noises and stimuli in general made people feel cut-off and alone, and less real in the night; but that this was not serious.

The next morning her surgeon informed me that she was demanding to be released from the hospital, and that he saw no orthopedic reason to oppose this. She was permitted to leave. She was somewhat apprehensive about this and wondered about how convalescence at home would proceed, but we recognized together that being home would make her feel more real, that as she reestablished her muscle tone she would soon be able to get back to work, that she should anticipate some nervousness until she fully resumed her roles both as the working and the supporting parent, and that she would undoubtedly feel better.

Conclusion

In review, then, we have a transaction between physician and patient which was meaningful and which was healing. This involved interpretation of and recognition of the need for an identity and a feeling of *selfness* as a unique person, as *a-being-in-the-world*, the individual world of the person herself. In being ill, her roles were changed, her image of herself jolted, her identity diffused. She had felt a loss of control, anxiety and guilt, and had tried to defend herself with repression and bracing. The symptoms had increased. The mechanisms of regression, denial and reversal were used with increasing panic. Primary process material invaded the present situation as ego controls diminished, and she had been threatened with total decompensation.

The therapeutic consultation made use of transference, and the existential question, "Tell me about your world" provided the framework in which all of this could be fitted together and utilized for a therapeutic encounter.

Bibliography

1. Brenner, Charles: An Elementary Textbook of Psychoanalysis. New York: Int. Univ. Press, 1955.
2. Erikson, Erik H.: Young Man Luther. New York: W. W. Norton, 1959.
3. Fenichel, Otto: Outline of Clinical Psychoanalysis. New York: W. W. Norton, 1934.
4. May, Rollo, Angel E., and Ellenberger, H. F.: Existence. New York: Basic Books, 1958.
5. Reich, Wilhelm: Character Analysis. New York: Orgone Institute Press, 1949.
6. Sullivan, Harry S.: Conceptions of Modern Psychiatry. New York: W. W. Norton, 1940.

Ludwig's Angina with Associated Acute Glomerulonephritis

A Discussion with Report of a Case

Don G. Davis, M.D.
Robert B. Burrell, M.D.
Kalamazoo, Michigan

RECENT literature concerning Ludwig's angina is sparse. Although this process has a rich history,[24] present-day therapeutics, in the form of early and intensive antibiotic therapy, has reduced its incidence to near the vanishing point. Nevertheless, sporadic cases do occur and present what may become demanding problems. This communication is submitted to document a recent case coexistent with acute glomerulonephritis.

Historical

Although some writers[33] have felt Ludwig's angina is synonymous with a great variety of conditions, the disease has been well characterized by a number of authors; including particularly Ashhurst,[2] Davis,[12] Grodinsky,[15,16] and Thomas.[36] These authorities have explored in detail the fascial spaces and planes of the neck. All agree essentially with Ashhurst, who states, "(Ludwig's angina) is an acute inflammatory process involving the floor of the mouth and the submaxillary region on one or both sides of the neck. It is the simultaneous involvement of the submaxillary and sublingual tissues in a confluent septic cellulitis that warrants the condition being recognized as a distinct clinical entity." Williams[37] goes on to add, "Clinical manifestations of infection in both of these regions are prerequisite for a diagnosis. Other spaces may or may not be involved."

Current surgical texts[4,5,9,20,23] seem in basic agreement with Ashhurst and Williams, but interesting paradoxes are present.[1,13] One current text dismisses Ludwig's angina in an early chapter as "a vague term applied to diffuse swelling of the neck . . .;" while a few pages later it states, ". . . a typical Ludwig's infection involves all three compartments, the sublingual, submaxillary, and submental, on either one or both sides of the midline."

Ludwig himself was apparently not the first to describe the condition which bears his name. At least two authors have fixed the source of the first description of this angina as Hippocrates.[22,24] Paulus of Aegena, Areatus, and Galen are also credited with having recognized it. In the more recent remote writings, Wells (1809), Gregory (1822),[15,36] and Gensoul (1830)[10] antedated Wilhelm Frederick von Ludwig, the physician who in 1836 published the untitled article[7] responsible for his fame. Since Ludwig's time, there have been many articles concerning the clinical findings, either supporting or disputing the contention that Ludwig's angina is truly a distinct clinical syndrome. Most recent authors are agreed that the condition is distinctive and, although uncommon, of sufficient importance to be considered a clinical entity.[19] Ashhurst states it succinctly, "If physicians refuse to give it such recognition, they are making a backward step comparable to that which would be taken if they still refused to recognize the clinical entity appendicitis as distinct from typhlitis or enteritis or peritonitis."

Characterization

Clinically, Ludwig's angina is a striking condition. In the full-blown case, the patient presents with a marked tender swelling from chin to hyoid bone. The tongue is elevated and may protrude between the teeth. Because of the swelling, there is difficulty closing the mouth and swallowing may be impossible. Dyspnea is prominent and the obstruction may rapidly become complete. The suprahyoid swelling has been described as "brawny" or "woody" and fluctuation is rare. Most frequently a dental origin has been incriminated, but Kimbrig quotes Stewart[34] as stating there are "over thirty-five causes of cellulitis of the face and neck," so the condition may be generated from many sources.

As stated above, the uniqueness of Ludwig's angina lies in the coincident involvement of both submaxillary and sublingual tissues. Briefly, this involvement of the submandibular space[15] (Grodinsky) involves infection in an area limited superiorly by the mucous membrane of the floor of the mouth; anteriorly and

laterally by the inner surface of the mandible; antero-inferiorly and infero-laterally by the superficial layer of deep cervical fascia; inferiorly by the hyoid bone, hyoglossus muscle, and visceral fascia over the superior pharyngeal constrictor muscles; and in communication supero-laterally with the lateral pharyngeal space. The submaxillary and submental compartments are separated from the sublingual by the diaphragm-like mylohyoid muscle and communicate at its extreme posterior border, around which curves the submaxillary gland.

Classifically, treatment has been by deep incisions through the submental region to or through the sublingual mucosa. The purpose of these incisions is not primarily to establish drainage, for frequently there is little or none, but to relieve pressure in this confined space. If this is not done rapidly, there may be mediastinitis through extension along fascial planes, suffocation by laryngeal compression or glottic edema, or large tissue loss due to pressure necrosis.[37] With the advent of antibiotics, therapy has shifted somewhat so that there are several reports of Ludwig's angina having been successfully treated without operation,[21,26] as was the present case. Operation is suggested only to prevent likely complications.

Analysis of causative organisms[12,25,35,37] has revealed a great preponderance of streptococcal or mixed streptococcal-staphylococcal or streptococcal-pneumococcal infections, although occasionally, gas-forming organisms[25,37] and other bacteria have been discovered.

With such therapy, mortality has decreased from earlier reports of 40 to 60 per cent[27,35] to as low as 10 per cent in 1943.[38] Large series in the present time would probably show mortalities of 5 per cent, or even less.

Acute Glomerulonephritis

Acute glomerulonephritis is perhaps a somewhat less exotic clinical syndrome. It is well known that acute glomerulonephritis has been established as a complication of infection with a nephritogenic type of group A streptococcus, most frequently of Type 12.[29,32] Frequently there is nothing remarkable about the preceding streptococcal infection, and it may not be noticed. From one to four weeks later,[14,29] a typically severe case will have the sudden onset of hematuria, edema, and hypertension. Proteinuria, hematuria, and probably red blood cell casts will be noted on laboratory examination. Other than treatment of the streptococcal infection, if still present, definitive care is limited to bed rest and careful control over nutrition, fluids, and the hypertension.[18,29,32] Steroids may be considered.[11] In 95 per cent or more of children who have the acute form of the disease, recovery is spontaneous and complete; however, with onset of the acute phase as adults, the per cent who have eventual chronic glomerulonephritis is thought to be greater than fifty.[32]

The following case report, we believe, represents, so far as a careful review of the literature can tell, the first documented episode of acute glomerulonephritis associated with Ludwig's angina:

Case Report

R. McK., a forty-year-old white businessman, had a subtotal septal reconstruction on October 24, 1959, for severe septal deviation and chronic irritative rhinitis. Blood pressure was 130/90 and urinalysis not abnormal during this two-day hospitalization. Following release, the septal wound healed well, but there was some continued crusting and bloody discharge from the nose. About January 30, 1960, the patient noted tenderness and swelling in the right submaxillary area. These complaints persisted, and on February 4, 1960, there was the acute onset of pain within the left ear and below the angle of the left jaw. One of us (R.B.) was called and the patient was given 400,000 units SR penicillin intramuscularly. Despite medication, the swelling progressed beneath the jaw and the suprahyoid region became very tense. Temperature reached 101 degrees as read by the patient, and he was seen in the office as an out-patient at 3:30 P.M., February 6, 1960. About 3:00 P.M., he had voided the first recognized "coffee-colored" urine specimen. After examination, he was hospitalized.

Past history revealed no previous history of scarlet fever, tonsillitis, glomerulonephritis, or rheumatic fever. One daughter had had what was apparently acute glomerulonephritis eight years previously.

Physical examination revealed a large, moderately obese white man who was febrile and toxic. Blood pressure 150/90, temperature 102 degrees orally. The submandibular area was massively swollen and tender. No fluctuation could be detected and the consistency of the neck was "woody." The mouth was held open, and the tongue forced against the roof of the mouth. Pharynx could not be seen. Periorbital and pedal edema were noted.

The patient was given 400,000 units SR penicillin on admission and b.i.d. One thousand cc. 5 per cent glucose in saline was given intravenously. A tracheotomy set was placed at bedside. No throat culture was taken.

The patient progressed well. Some dyspnea was present through the night of February 5, 1960, but by 10:00 A.M., February 6, 1960, the swelling had receded sufficiently to permit unobstructed breathing. Direct inspection and indirect laryngoscopy showed the uvula and soft palate to be ecchymotic and swollen. There was moderate edema of epiglottis and soft tissues of the laryngeal folds. Submaxillary areas were still firmly swollen, but somewhat less prominent. Laboratory examinations revealed protein-uria with marked hematuria and numerous granular casts. White blood count was 13,050 with 89 per cent neutrophils. Antistreptolysin 0 titer was positive at 100 Todd units. By February 9, 1960, submandibular tenderness was nearly gone, and the swelling had decreased markedly. The patient swallowed easily. Urine output, which was estimated at 800 cc. on February 6, fell to 610 cc. on February 8, and 750 cc. on

February 9, but thereafter rose above 1,000 cc. per day for the remainder of his hospitalization. White blood count fell to below 10,000 by February 7. Urinalyses continued to show proteinuria and microhematuria until his discharge. One blood cast was found on February 12. The patient's blood pressure, which had been elevated only slightly on admission, rose to 170/95 on February 11, and to its peak of 220/130 on February 15. No funduscopic changes were seen, and by the afternoon of February 15, had receded to 185/115. Over the next three days, it fell to 170/105, and hypotensive medications were not used while the patient was hospitalized. On February 15, antistreptolysin 0 titer was 333 Todd units.

The patient was kept at bed rest throughout the two weeks of hospitalization and discharged on oral penicillin to convalesce at home. His progress at home has been satisfactory. Urinalyses were negative for protein by April 6, though microhematuria was still present on May 6. Blood pressure fell gradually and was 140/100 on April 8; at this time, he was placed on a hypotensive agent. On May 6, when blood pressure was 130/85, this was discontinued.

Discussion

It is not difficult to see how Ludwig's angina and acute glomerulonephritis might become related. About 70 per cent of the cultures taken from patients with Ludwig's angina proved to contain streptococci, as stated above. It is not unlikely that a nephritogenic strain would be involved. No throat cultures of this patient were taken; however, as stated by Rammelkamp,[28] modern antibacterial therapy alters the flora of the respiratory tract, making isolation of the bacteria responsible for kidney disease difficult, if not impossible. In the present patient, who received penicillin at home well before his hospitalization, we feel culture would most likely have been negative.

In this case, the timing of the onset of symptoms with the eventual acute production of *both* the Ludwig's angina and the acute glomerulonephritis is such as to suggest they came from a common source: a pharyngitis, or perhaps rhinitis.

While prior reports of Ludwig's angina associated with acute glomerulonephritis have not been published, one report, to our knowledge,[30] has appeared in the French literature reporting the coexistence of Ludwig's angina, diabetes, and "Bright's disease." Analysis of the article tends to indicate that the patient reported may have had either a Kimmelstiel-Wilson syndrome or chronic glomerulonephritis, but not acute glomerulonephritis.

The possibility that acute glomerulonephritis has occurred previously in patients with Ludwig's angina is high. Rammelkamp[29] points out that in the course of acute glomerulonephritis, there may be minimal hematuria with onset of the streptococcal disease which clears and is followed by development of the acute syndrome at the indicated time, approximately ten days later. Patients reported by Ashhurst had albuminuria and hematuria during the course of their Ludwig's angina. No doubt other patients also had similar findings. If these patients had recovered, they might later have developed an acute glomerulonephritis. Nevertheless, all patients whose reported case histories we have studied and who had symptoms similar to these, died from their Ludwig's angina. It is possible that patients, severely ill with Ludwig's angina, who also developed renal hypersensitivity reactions to the streptococci responsible, were unable to recover. The combination of both conditions, even with radical surgery, might well be sufficient to have caused death. If this is true, as a greater per cent recovery from Ludwig's angina, the incidence of acute glomerulonephritis in these patients may rise. It is suggested that this possibility be kept in mind as another complication of the syndrome, Ludwig's angina.

Summary

1. Ludwig's angina is a distinct clinical entity characterized by acute inflammation of the "submaxillary and sublingual tissues in a confluent septic cellulitis."[2]

2. The classical therapy—deep, extensive submaxillary incision—has been supplemented and often replaced by antibacterial treatment, largely in the form of massive doses of penicillin.

3. The first reported case of the association of Ludwig's angina and acute glomerulonephritis is presented.

4. The two conditions are felt to be related in the patient presented because (a) the organism which may be responsible for acute glomerulonephritis is the most frequent cause of Ludwig's angina and (b) the latent period of acute glomerulonephritis corresponds well with the prodromal period of this patient's Ludwig's angina.

5. Glomerulonephritis may be considered another possible complication of Ludwig's angina.

References

1. Anson, B. J., and Maddock, W. G.: Callender's Surgical Anatomy. 4th ed., pp. 149-150, and 175, Philadelphia: W. B. Saunders Co., 1958.
2. Ashhurst, A. P. C.: Ludwig's angina. A.M.A. Arch. Surg., 18:2047, 1929.
3. Bailey, H.: Ludwig's angina. Practitioner, 127:365, 1931.
4. Bailey, H., and Love, McN.: A Short Practice of Surgery. 11th ed., pp. 196-197. Philadelphia: J. B. Lippincott Co., 1959.
5. Ballenger, H. C., and Ballenger, J. J.: Diseases of the Nose, Throat, and Ear. 10th ed., pp. 309-312, Philadelphia: Lea and Febiger, 1957.

6. Bean, D. M., and MacKenzie, W. C.: The use of penicillin in Ludwig's angina. Canad. M.A.J., 52:568, 1945. Quoted by Kelly, Hodge, and Grossman.
7. Burke, J.: Angina Ludovici. Translation, with Biography of Wilhelm Frederick von Ludwig. Bull. Hist. M., 7: 1115, 1939.
8. Cluff, L. E.: Management of acute streptococcal infection in relation to rheumatic fever and glomerulonephritis. Postgrad. Med., 19:2, 1956.
9. Cole, W. H., Ed.: Cole and Elman Textbook of Surgery. 7th ed., p. 124, New York: Appleton-Century-Crofts, Inc., 1952.
10. Colp, R.: The treatment of deep infections of the submaxillary triangle. S. Clin. North America, 13:315, 1933.
11. Danowski, T. S., and Mateer, F. M.: Therapy of acute and chronic glomerulonephritis. J. Chron. Dis., 5:122, 1957.
12. Davis, G. G.: Acute septic infection of the throat and neck: Ludwig's angina. Ann. Surg., 44:175, 1906.
13. Davis, L., Ed.: Christopher's Textbook of Surgery. 7th ed., pp. 256 and 304-306, Philadelphia: W. B. Saunders Co., 1960.
14. Earle, D. P., and Seegal, D.: Natural history of glomerulonephritis. J. Chron. Dis., 5:3, 1957.
15. Grodinsky, M.: Ludwig's angina. Surgery, 5:678, 1939.
16. Grodinsky, M.: Ludwig's angina, retropharyngeal abscess, and other deep abscesses of the head and neck. J.A.M.A., 114:18, 1940.
17. Hall, C.: Suprahyoid neck infections. Laryngoscope, 60:779, 1950.
18. Harrison, T. R., Adams, R. D., Bennett, I. L., Jr., Resnik, W. H., Thorn, G. W., and Wintrobe, M. M., Ed.: Principles of Internal Medicine. 3rd ed., pp. 857-868, New York: McGraw-Hill Book Co., Inc., 1958.
19. Herd, R. M., and Hall, J. F.: Ludwig's syndrome. Oral Surg., 4:1523, 1951.
20. Jackson, C., and Jackson, C. L., Ed.: Diseases of the Nose, Throat and Ear. 2nd ed., p. 208, Philadelphia: W. B. Saunders Co., 1959.
21. Kelly, J. J., Hodge, G. E., and Grossman, A.: Ludwig's angina. Canad. M.A.J., 77:1089, 1957.
22. McCaskey, C. H.: Ludwig's angina. A.M.A. Arch. Otolaryng., 36:467, 1942.
23. Moseley, H. F., Ed.: Textbook of surgery. 3rd ed., pp. 355-356, St. Louis: C. B. Mosby Co., 1959.
24. Muckleston, H. S.: Angina ludovici and kindred affections: An historical and clinical study. Ann. Rhin. & Laryng., 37:711, 1928.
25. Murry, C. M., Jr., and Fisher, G. E.: The modern treatment of Ludwig's angina. Mississippi Doctor, 23: 580, 1946.
26. Player, G. S.: Treatment of Ludwig's angina. Northwest Med., 48:480, 1949.
27. Prudhon, C. A., and Harberson, J. D.: Certain serious deep infections in the neck. North. New York M.J., 4:9, 1947.
28. Rammelkamp, C. H., Jr.: Microbiological aspects of glomerulonephritis. J. Chron. Dis., 5:28, 1957.
29. Rammelkamp, C. H., Jr.: Prevention of acute nephritis. Ann. Int. Med., 43:511, 1955.
30. Riche, Aussilloux, and Fabre, M. M.: Angina de Ludwig chez un diabetique atteint de mal de Bright. Arch. soc. d. sc. méd. et. Biol. De Monpellier, 19:367, 1938.
31. Ross, G. G.: Angina Ludovici. Ann. Surg., 33:720, 1901.
32. Schneckloth, R. E., and Page, I. E.: Glomerulonephritis in adults. M. Clin. North America, 39:975, 1955.
33. Semon, F.: On the probable pathologic identity of the various forms of acute septic inflammation of the throat and neck. Med.-Chir. Tr., Royal Med. and Chir. Soc. Lond., 78:181, 1895. Reported by Ashhurst, Davis, Grodinsky and others.
34. Stewart, M. B.: Deep infections of the neck. Mill. Surg., 91:426, 1942. Quoted by Kimbrig, M.: Deep cellulitis of the face and neck. A.M.A. Arch. Otolaryng., 42:415, 1945.
35. Taffel, M., and Harvey, S. C.: Ludwig's angina. An analysis of forty-five cases. Surgery, 11:841, 1942.
36. Van Wagenen, W. P., and Costello, C. V.: Sublingual phlegmon. Primary and secondary Ludwig's angina. Ann. Surg., 87:684, 1928.
37. Williams, A. C.: Ludwig's angina. Surg. Gynec. & Obst., 70:140, 1940.
38. Williams, A. C., and Guralnick, W. C.: The diagnosis and treatment of Ludwig's angina. A report of twenty cases. New England J. Med., 228:443, 1943.

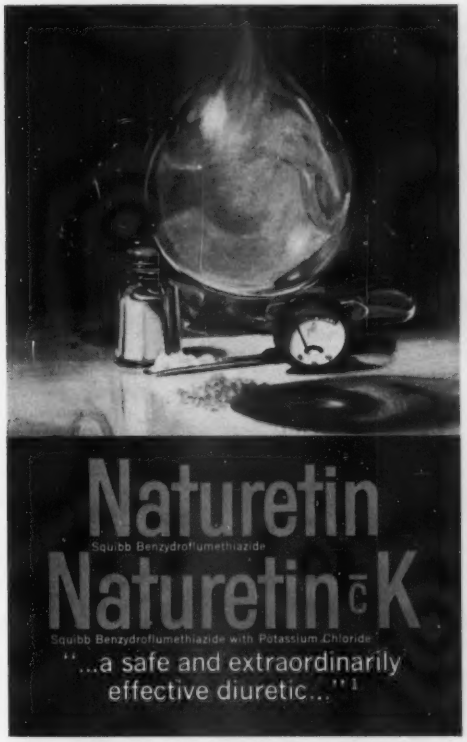
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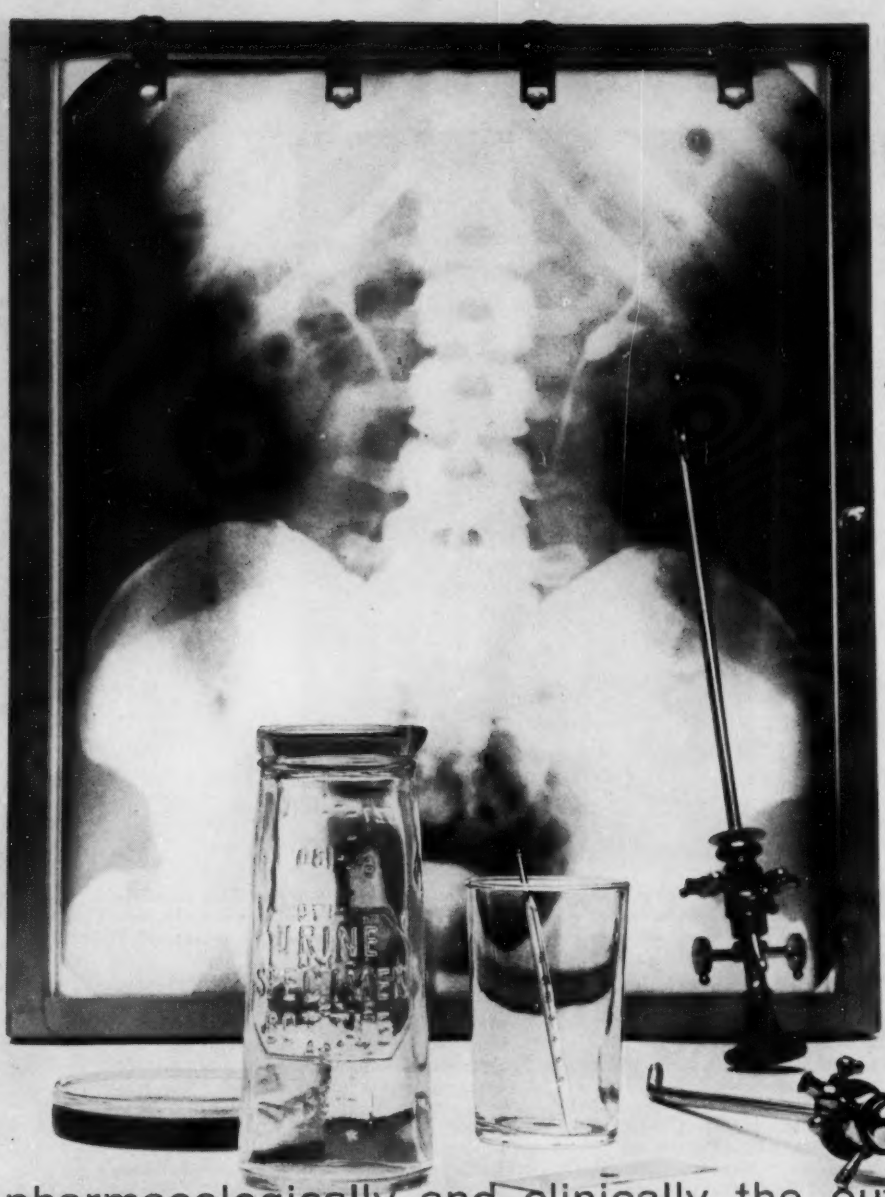
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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 8:60 (Feb.) 1960. 2. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 8:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H., and Newman, B.E.: Op. cit. 8:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. 8:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 6. Cohen, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 9. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 13. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy 8:1 (Feb.) 1960.

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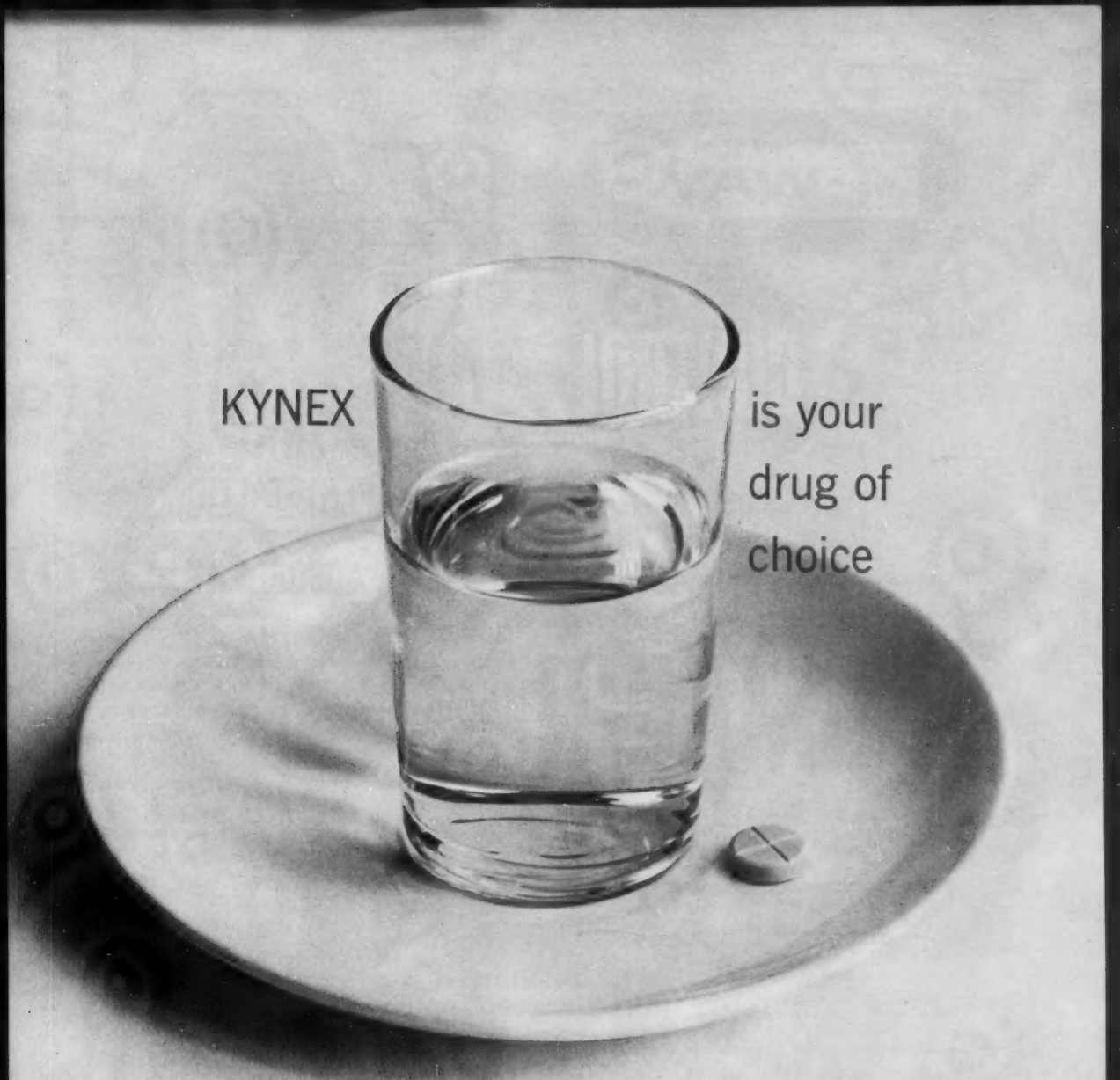
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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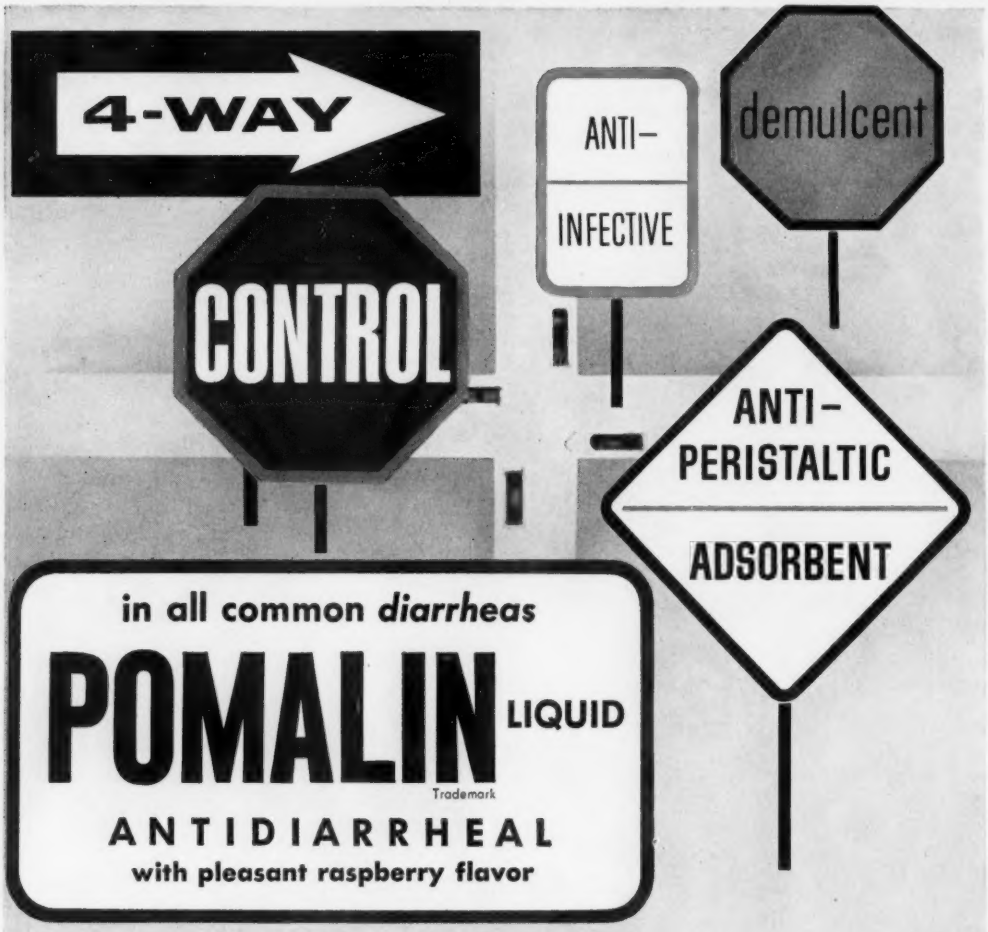
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The Office and Out-Patient Treatment of Leukemia

Robert B. Burrell, M.D.
August F. Fath, M.D.
Paul S. Rutherford, M.D.

Kalamazoo, Michigan

THE CONCEPT of the out-patient treatment of leukemia is not new, but re-emphasis in this direction is needed because of accelerated community and population growth. Hospital facilities should be reserved for the acutely ill; the leukemic patient, until he develops one of the serious complications of his disease, can usually be managed at home and may continue at his occupation. Leukemia is one of the major medical problems of the present and is increasing in its incidence.[1] In the future, an increased number of patients may make the out-patient system of treatment a necessity. All of the laboratory procedures for the diagnosis and treatment of leukemia can be performed without the patient's formal admission to hospital. Peripheral blood studies, transfusions and bone marrow aspirations can be performed in the hospital laboratory or emergency room area. The patient is spared the unnecessary expense of a hospital room during the major portion of his illness.

In this community there is intimate cooperation with pathologists who are interested in clinical medicine. This cooperation is personal and close rather than an impersonal interpretation of material such as blood smears. This type of assistance by "clinical pathologists" is most important in leukemia management. Early in 1958, a group of local physicians and scientists formed the Borgess Hospital Blood Research Group. The purpose of the group is to investigate the causes and assist in the management of disorders of the hematopoietic system. Informal meetings are held in the pathologist's office where cases are discussed, blood and bone marrow preparations are reviewed, and treatment ideas are exchanged. Any physician with a leukemic patient may present the case for discussion and assistance. Meetings are held according to care-need and not on a set schedule. Arrangements for presentation of a case are usually made with one of the pathologists. The attending physician has full responsibility for the management of his patient; he may or may not choose to follow the suggestions of the group. After the initial meeting, close cooperation is maintained between the attending doctor, the patient and the pathologist. For instance, a patient may visit the laboratory and by pre-arrangement receive a blood transfusion if his hemoglobin is below a given level; at the same time the pathologist may telephone the current laboratory results to the attending physician, who then determines when the patient should return for further laboratory tests and/or for a visit to the physician's office.

The patient retains his personal physician and in the process retains his individuality as a person rather than a case number. When complications or problems occur, the physician may bring them to the group. An individual physician may have only a small number of leukemic patients, but his active participation in the discussions and decisions of the group enable him to treat his patients with confidence.

Diagnosis

The clinical findings associated with the recognition of leukemia are well documented and will not be discussed. The classification into acute, subacute or chronic; lymphocytic, granulocytic or monocytic; leukemic, subleukemic or aleukemic; is subject to so much difference of opinion in the literature that we have rather rigidly followed the recommendations of the joint committee on nomenclature of the American Medical Association and the American Society of Clinical Pathologists.[2]

Acute Leukemia

Our routine laboratory investigation of a new leukemic patient includes a complete blood count, hematocrit, platelet count, bone marrow smears and paraffin sections of bone marrow aspirate. Most patients with acute leukemia require weekly visits to their doctor's office and the laboratory initially: these may be stretched to every two weeks as treatment becomes more stablized. The hemoglobin level has afforded the best single objective criterion of response to treatment. Reticulocyte counts are often of value as treatment progresses because, in our experience, a rise

From the Department of Medicine and Pathology, Borgess Hospital, Kalamazoo.

or fall in the reticulocyte count precedes a rise or fall in the hemoglobin by a week or two in most instances. Occasionally, the patient must return twice a week, usually for transfusions during a period of relapse, as when he has ceased to respond to one cytotoxic drug and a new drug has not yet become effective.

Chemotherapy is the treatment of choice for acute leukemia. We have achieved our best results with 6-mercaptopurine in oral dosage of about 1 mg. per pound per day; there is a lag period of seven to ten days before any reduction of leukocytes is noted; toxic side reactions have been notably scarce. Some patients may respond to methotrexate, adult dose about 5 mg. per day by mouth, after they no longer respond to 6-mercaptopurine. Methotrexate may be increased to as much as 10 mg. per day in the adult if no therapeutic response is obtained with lesser doses and if no toxic effects have occurred. Toxic reactions such as mouth ulcers, diarrhea, bone marrow depression, alopecia and skin pigmentation, are more frequent with methotrexate than with 6-mercaptopurine, and any single one of these reactions is an indication for stopping the drug.

Adrenal corticosteroids should be used only sparingly in acute leukemia and, generally speaking, should be reserved for temporary usage in emergencies. They may aggravate the clinical and hematologic picture in acute granulocytic and monocytic leukemias. Their greatest usefulness is in the acutely hemorrhagic, platelet deficient patient where they may control bleeding. They may also control the hemolytic anemia which occasionally occurs as a complication of leukemia. In patients in whom hemorrhages are a constantly recurring problem, a low daily dose of corticosteroid will sometimes obviate the necessity for platelet transfusions. Steroids in large dosage should be tried in patients with lymphocytic leukemia after they have developed resistance or have failed to respond to the cytotoxic drugs.

Chronic Leukemia

Chronic lymphocytic leukemia, without symptoms or significant anemia, and with a leukocyte count below 100,000, requires no treatment; the patient should be checked at regular intervals to intercept the advent of a more severe phase of his disease. When this occurs, the initial drug of choice is chlorambucil (Leukeran) in daily dosage of 0.1 to 0.2 mg. per kg. body weight. Patients refractory to this drug may be tried on the more toxic nitrogen mustard or triethylene melamine. Localized radiotherapy to tumor masses, enlarged lymph nodes or enlarged spleen may shrink the local tumor with ameliorization of symptoms. In advanced cases, continuously administered steroids, in low to moderate doses, are of value.

Chronic granulocytic leukemia should probably be treated as soon as it is firmly diagnosed. Early cases often present a confusing hematologic picture which is difficult to differentiate from other members of the myeloproliferative disease group. In the absence of symptoms, treatment directed toward keeping the leukocyte count below 20,000 is satisfactory. The drug of choice is Myleran, 4 to 6 mg. orally per day initially, reduced to a maintenance dose of 2 mg. several times weekly after the leukocyte count has dropped below 20,000. Some clinicians stop treatment with remission, but we believe that the psychologic impact of restarting the drug is more upsetting than the act of increasing dosage when exacerbation occurs.

Blood Transfusions

The following points have been learned from experience:

1. A practical compromise with normal hemoglobin levels, when transfusions are required to keep the hemoglobin up, is 9 to 10 grams for men and 7 to 9 grams for women. These levels in a travelling salesman and in a housewife, both with acute granulocytic leukemia, enabled them to continue with their normal duties for eighteen months before their disease became terminal. The salesman continued to make selling trips and the housewife did the work in her household of four people. Attempts to keep the hemoglobin higher were disappointing. More numerous transfusions were required and the patients showed little benefit from the higher hemoglobin levels.

2. Fresh blood, not older than a week, should be used. As blood approaches its out-dating period, the boost it gives to the patient is of shorter duration.

3. Platelet-rich blood, preferably drawn in plastic containers the same day it is given, can be of value when bleeding becomes a problem. Platelet counts are not good criteria for this type of transfusion; some patients do not bleed with platelet counts as low as 20,000 per cu. mm., while other patients bleed with counts as high as 70,000. Skin petechiae are not sufficient indication for platelet transfusion; some patients with almost constant petechiae seldom have more serious hemorrhages. Hematuria or large ecchymoses, on the other hand, should be treated promptly and will frequently clear up following a single platelet transfusion.

4. All leukemic patients, as candidates for repeated transfusions, should have soluble corticosteroid added to the blood bottle before the transfusion. We most frequently used hydrocortisone sodium succinate* in 10 to 100 mg. dose or methyl prednisolone sodium succinate† in 4 to 40 mg. dose. These effectively prevented the transfusion reactions which so frequently occurred, usually after the tenth transfusion, in the days before we used corticosteroid in this way.

5. As transfusional therapy progresses, the patient's veins become more important assets to him; every effort should be made to keep these in good repair. The total number of venepunctures should be kept low; blood counts and hemoglobin determinations should be done on skin puncture blood rather than venous blood. Where feasible, blood for cross-matching should be stored in sterile condition in the refrigerator from transfusion to transfusion, so that a separate venepuncture to obtain serum for cross-matching be not necessary. Venepuncture should be performed only after thorough skin sterilization by an experienced person who is aware of the importance of maintaining venous integrity and avoiding local infections. A preventable staphylococcal skin infection and localized phlebitis occurred as a result of careless venepuncture in one of our child patients; if not only rendered a vein unusable but required over six months' treatment to control the infection.

Infections

Leukemic patients are susceptible to infections of all kinds and, when infected, tend to be resistive to treatment. When infection occurs, every effort should be made to secure a culture and antibiotic sensitivity before treatment is begun. The virtue of this lies in the avoidance of wide spectrum antibiotics when a narrower spectrum antibiotic, such as penicillin, will suffice. The wide spectrum antibiotics are well known potential producers of fungus infections. One of our patients ran a nail into her foot and received wide spectrum antibiotics; she developed persistent laryngitis and bronchitis due to Candida albicans infection; at autopsy, Candida albicans was found in liver abscesses. Another patient developed diffuse, ulcerative enteritis; fungi were identified in autopsy sections of the small intestine.

Concerning the use of prophylactic antibiotic therapy, we think that in most instances this is not justified; that there should be prompt, energetic treatment of infections when they occur. In one patient with acute leukemia, however, prophylactic penicillin evidently prevented gingival and respiratory infections for more than a year.

Summary and Conclusions

A method for the office treatment of leukemia is described. The authors believe that this mode of treatment causes the least possible dislocation to the family and business life of the patient; that it is economical for the patient and the physician; that it preserves the patient's individuality and morale. We quote two of Grigg's dicta of palliation[3] to which we strongly subscribe, namely "Only one physician shall be in charge of the patient. Consultation may be required, but the patient's body and mind must be in the hands of one physician," and "The family finances shall be considered in connection with the cost of medical, surgical, radiological, hospital and nursing care."

References

1. Heyssel, R., Brill, A. B., Woodbury, L. A., Nishimura, E. T., Ghose, T., Hoshino, T., and Yamasaki, M.: Leukemia in Hiroshima atomic bomb survivors. Blood, 15: 313, 1960.
2. Third, Fourth and Fifth Reports of the Committee for Clarification of the Nomenclature of Cells and Diseases of the Blood and Blood-forming Organs. Am. J. Clin. Path., 20:562, 1950.
3. Grigg, E. R. N.: Etymologic and other aspects of palliation (Editorial). Am. J. Roentgenol., 80:863, 1958.

136 E. Michigan Avenue

*Solu-Cortef, Upjohn Company.

†Solu-Medrol, supplied free by the Upjohn Co., Kalamazoo, Michigan.

Estrogen and Heart Attacks

Women have a built-in protection against heart attacks, according to Park Willis, III, M.D., associate professor of internal medicine at The University of Michigan Medical Center. Estrogen, the female sex hormone, prevents the occurrence of arteriosclerosis, or coronary artery hardening, which is often a contributing cause of coronary disturbances. The reason why estrogen acts as a deterrent to heart attacks has not yet been confirmed.

Estrogen is developed in the ovaries and is present throughout most of a young woman's life. This protective agent diminishes after the menopause. Women then may begin developing conditions which lead to arterial narrowing, such as the deposition of cholesterol. By comparison, men become susceptible some twenty to thirty years earlier.

There has been some treatment of coronary diseases using estrogens to help prevent attacks. Results seem to be good.

Surgical Significance of Subarachnoid Hemorrhage

Preston S. Weadon, M.D.
Kalamazoo, Michigan

THE INTRODUCTION of cerebral angiography has changed the entire concept of subarachnoid hemorrhage. The time-honored diagnosis of "spontaneous subarachnoid hemorrhage" is no longer acceptable since it is now frequently possible to establish a specific etiology by means of cerebral angiography. This syndrome is always serious, but its prognosis is to a considerable extent dependent upon the specific etiology. A recent review by Mc Kissock[2] of 455 patients with subarachnoid hemorrhage showed that 57 per cent, or over half the series, was due to intracranial aneurysm. Unexplained hemorrhage accounted for 26 per cent, and cerebral or cerebellar hemorrhage for 10 per cent of this series. Intracranial angioma was found in only 6 per cent. The importance of diagnosis is evident from a consideration of the death rate as exemplified by the above series. Despite the high total mortality of 38 per cent, great variation was noted in the different etiologic groups. Whereas 70 per cent and 46 per cent mortality was noted for cerebral hemorrhage and aneurysm respectively, only 14 per cent mortality occurred in the unexplained group. It is generally stated that the overall mortality in untreated intracranial aneurysm is anywhere from 30 per cent to 60 per cent. Since aneurysm is the only cause in which specific surgical treatment is of proven value, and since this is also one of the major causes of subarachnoid hemorrhage, establishment of etiology is of unquestioned importance. This ultimately hinges upon radiographic demonstration of the cerebral vasculature by means of cerebral angiography. Logical treatment can be planned only by demonstration of the lesion or of normal vasculature. Angiography is therefore of vital importance in both treatment and prognosis.

Patients with subarachnoid hemorrhage are usually first seen by their personal physicians (in most cases a generalist or an internist). Excluding cases of obvious trauma, the hemorrhage itself is usually the first occurrence even when due to aneurysm. There is usually nothing clinically apparent by which aneurysm can be differentiated from other causes. Occasional exceptions to this are the occurrence of ocular palsies (particularly the oculomotor nerve), pain in the ophthalmic division of the trigeminal nerve, and rarely the history of prior episodes of typical headache. The presence of known hypertension or advanced age of the patient makes the diagnosis of aneurysm somewhat less likely but does not preclude its presence. The usual case is of abrupt onset with severe sudden headache, often suboccipital, occasionally generalized in location, frequently extending into the neck, shoulders, and even down the back and backs of the legs. There may be nausea, vomiting, dizziness, even collapse with loss of consciousness. There may be signs of brain damage such as hemiplegia or hemiparesis. Occasionally the history is less obvious, with several days of rather severe headache, nausea, vomiting, low-grade fever, and stiff neck, which may be diagnosed erroneously as "flu," "URI," or even poliomyelitis. Meningeal signs, such as stiff neck, Kernig's and Brudzinski's signs, fever, and photophobia are sometimes delayed in their appearance and may develop two or three days after the hemorrhage. If there is any question of the possibility of subarachnoid hemorrhage, a spinal puncture should be done. The presence of blood, or xanthochromia in cases in which the puncture is delayed for a few days, usually confirms the diagnosis of subarachnoid hemorrhage. The spinal fluid pressure will often be elevated. The demonstration of blood in the spinal fluid will then lead to adequate investigation. It is trite but true that a high index of suspicion on the part of the physician is necessary in order to detect cases of aneurysm and by timely and appropriate therapy offer a substantial number of patients a better outlook. In the majority, ruptured aneurysm is an explosive disease with a high risk to life with the initial hemorrhage. Many will die without any chance of treatment. Surgery, however, now can offer a much better prognosis to those who survive the initial hemorrhage. The most fortunate are those who survive the original hemorrhage with no loss of neurologic function and in whom angiography is performed and definitive surgical treatment carried out. Those in whom treatment is not carried out live under a constant threat of recurrent hemorrhage with its attendant risks of brain damage and death. While the risks of surgery are substantial,

the risk of recurrent hemorrhage is far greater. The aim of surgery is prevention of another rupture. Surgery cannot undo neurologic damage already present. Except for evacuation of an occasional intracerebral hematoma, the surgery of intracranial aneurysm is entirely preventive. It is perhaps of additional importance to save these patients because of the high incidence of this disorder in the young and early middle-aged adult. The occasional patient with hemorrhage due to a cerebral angioma may also be offered a better outlook for life with appropriate surgery but many of these are essentially inoperable and the prognosis untreated is considerably better than that of the untreated aneurysm.

Discussion

The following group of cases is presented as a fairly representative experience with surgically treated intracranial aneurysms occurring in a middle sized Michigan city. The series is much too small to permit any statistical analysis or upon which to dogmatize. The first patient was operated upon in 1954, and only two more operations occurred in the following year; all the rest were operated upon subsequently. Because of the small size of the series, no attempt has been made to summarize many additional cases of fatal subarachnoid hemorrhage in which surgery could not be offered. Since October, 1956, definitive neurosurgical treatment has been carried out in seventeen cases of subarachnoid hemorrhage of which two were due to angiomas and fifteen to intracranial aneurysm. The diagnosis in all patients was made by cerebral angiography. In all but one patient the initial symptoms was due to subarachnoid hemorrhage. Of the sixteen patients with subarachnoid hemorrhage, spinal puncture revealed bloody or xanthochromic fluid in all. The spinal puncture was performed in all these patients by the referring physicians who thus were able to establish a definite diagnosis of subarachnoid hemorrhage. The anatomical distribution of the fifteen cases of aneurysm is shown in Table I.

There were two surgical fatalities in the fifteen patients, both occurring in aneurysms of the anterior communicating artery. In one of these patients erroneous interpretation of the angiogram led the surgeon to believe that the aneurysm possessed a neck adequate for ligation. At surgery it was found to be a sessile structure involving the entire length of the anterior communicating artery and both anterior cerebral arteries as well. Treatment was confined to wrapping the structure with muscle. The other fatality was a huge aneurysm in which an attempted trapping resulted in thrombosis of the entire left anterior cerebral artery. In the thirteen remaining patients, direct surgical attack was carried out in twelve, the other patient being subjected to a trapping procedure. No subsequent hemorrhages have thus far occurred in the thirteen who survived surgery, the follow-up covering two months to five and one-half years. Of the thirteen surviving aneurysm patients and the two patients with angiomas, one sustained a hemiplegia as a direct consequence of surgery. One of the aneurysm patients and one patient with angioma had preoperative hemiplegia as a result of the initial hemorrhage. One aneurysm patient revealed no aneurysm on his initial angiography, and six weeks later sustained another hemorrhage. Angiography was then repeated with demonstration of an aneurysm following which surgery was carried out. Mc Kissock[2] found twenty-two aneurysms at autopsy of thirty-four patients who had shown negative angiograms. No completely satisfactory explanation for this occurrence has been forthcoming, but it would seem possible that initial thrombosis within the sac followed by softening at a later time could explain the lack of demonstration of the aneurysm. It is also possible that angiospasm may have played a part in preventing adequate filling of the sac with contrast medium. It is to be noted that cervical carotid ligation alone was not carried out in any patient of this series. It is this writer's belief that occlusion of the carotid artery in the neck is inadequate treatment for the majority of intracranial aneurysms save for the infraclinoid group and large sessile aneurysms of the supraclinoid portion of the internal carotid artery. Despite the lower initial mortality from cervical ligation, the reported occurrence of recurrent hemorrhage after this procedure suggests that direct surgical attack with ligation or, infrequently, trapping, is preferable. In general, aneurysms of the infraclinoid portions of the internal carotid artery are not approachable and can only be treated by cervical carotid ligation. The direct surgical attack, where feasible, offers the best chance for complete and lasting exclusion of the aneurysmal sac from the circulation. Even in cases where the angiogram fails to reveal clear-cut demonstration of a neck, care-

TABLE I. DISTRIBUTION OF ANEURYSMS IN FIFTEEN PATIENTS

Internal carotid (including bifurcation)	8
Middle cerebral	3
Anterior cerebral (both proximal)	2
Anterior communicating	2

ful dissection of the aneurysm will result in a neck sufficient to tolerate a clip or ligature. Wrapping with muscle, with or without Gelfoam, Oxycel, or other materials, is sometimes performed in situations where neither ligation of the neck of the aneurysm nor trapping can safely be carried out. This procedure is probably ineffective in preventing recurrent hemorrhage but it serves the purpose of making the surgeon feel better. The admittedly limited experience of the author thus far nevertheless strengthens the belief that the direct surgical attack with particular attention to painstaking dissection of the aneurysm offers the patient the best chance, in the majority of aneurysm cases, for permanent successful protection from subsequent hemorrhage with its attendant risks.

Because of the importance of prompt recognition of the existence of an intracranial aneurysm, two of this series warrant further discussion. The first case is that of a forty-two-year-old man who came to our attention after three days of headache, stiff neck, back and posterior thigh pain, photophobia, and low-grade fever. This occurred in mid-autumn during a fairly heavy polio season. The initial diagnosis was poliomyelitis, but because a hospital regulation required immediate spinal puncture on all polio suspects prior to admission, the finding of bloody spinal fluid led to the appropriate diagnosis. Cerebral angiography then showed a saccular aneurysm of the internal carotid artery just proximal to the bifurcation. This was successfully clipped and an uneventful recovery ensued. The second case is that of a forty-five-year-old woman who developed a ptosis of her right eyelid. She then developed a dilated right pupil and because her symptoms progressed over a period of three weeks, she consulted an ophthalmologist who referred her for neuro-surgical evaluation. The patient showed no signs of subarachnoid hemorrhage and her spinal fluid revealed no blood nor other abnormality. Cerebral angiography revealed a large aneurysm at the bifurcation of the right internal carotid artery which was successfully ligated. She had a transient left hemiparesis and a slow improvement in her oculomotor nerve palsy. This was the only case in the present series without frank rupture of the aneurysm. In all the other cases, prompt suspicion of subarachnoid hemorrhage and spinal puncture by the referring physicians led to correct diagnosis and appropriate treatment.

The management of subarachnoid hemorrhage can be logically planned only by knowledge of the etiology. That due to aneurysm or angioma must be considered to be basically surgical unless proven inoperable by either direct or indirect means. The conservative, or medical, treatment of such patients consists essentially of maintenance at as nearly a basal level of living as possible. Essentially this means strict confinement to bed, avoidance of all physical exertion and emotional strain, mild sedation for restlessness, avoidance of narcotic drugs, and adequate management of bowel movements, particularly avoiding straining when on the bedpan. Many cases will completely recover from the immediate effects of the initial episode of hemorrhage on such a regime. This, however, is no treatment at all for the subsequent secondary hemorrhage which most probably will occur. The danger lies chiefly in the fact that the time of occurrence of the next hemorrhage cannot be predicted with any degree of accuracy. It is widely accepted that secondary hemorrhage from an intracranial aneurysm is particularly prone to occur within two to three weeks after the initial hemorrhage. This fact lends further urgency to the need for prompt recognition and definitive treatment. Norlen and Olivecrona[3] state that intracranial attack on ruptured aneurysms carried out within the first two to three weeks of the hemorrhage carries too high a surgical mortality and are thus inclined to defer major attack until a quiescent period of three weeks after the hemorrhage. In waiting for this optimal time, however, patients are going to be lost to recurrent hemorrhage. Since at present there are no completely reliable statistics from which conclusions can be drawn as to the superiority of early or delayed surgery, the decision regarding the time of operation is somewhat subject to the surgeon's philosophy. Early angiography, however, carries little risk and permits establishment of a definite diagnosis. The demonstration of a normal cerebral vasculature immediately removes surgery from consideration. Occasionally there is demonstrated by angiography an intracerebral hematoma which requires early removal. Early angiography, therefore, is important regardless of the demonstration of an aneurysm as the cause for the subarachnoid hemorrhage. Bilateral angiography should be carried out regardless of the suspected side of the presumptive lesion. Occasionally multiple aneurysms are disclosed. Hamby[1] reports their occurrence as 9.3 per cent. Only one such case has been personally encountered by the author and is not included in the present discussion because of its essential inoperability.

The gradual improvement in surgical techniques has led to increasingly widespread attack on aneurysms in recent years. All of the reported patients in this

series, save for the first two, were operated upon under endotracheal anesthesia with induced hypotension using intravenous Arfonad. In addition to reducing the normal blood loss of any standard craniotomy, induced hypotension renders more easily manageable the occasional rupture of the aneurysm during surgery, always a formidable complication. The employment of hypothermia is doubtless of value in reducing the oxygen requirements of the brain so that temporary occlusion of major vessels can be carried out when necessary. This technique has not yet been available at the author's hospitals, but it is hoped that it soon will be. More recently the use of intravenous urea has occasionally been employed where exposure has been a problem. The possible postoperative risks of delayed thrombosis and angiospasm have been routinely dealt with by the use of inhalations of carbon dioxide and intramuscular injections of papaverine. The one case of infraclinoid aneurysm in which direct surgical attack could not be carried out was treated by chronic occlusion of the internal carotid artery in the neck using a Salibi clamp. This was later removed and the compressed arterial segment excised and ligated. Still later a craniotomy was performed and the internal carotid ligated distal to the aneurysm. In one case of aneurysm of the anterior communicating artery and one middle cerebral aneurysm, neither of which could be ligated nor trapped without risk of irreparable hemiplegia, wrapping of the aneurysm with muscle was carried out.

The two cases of cerebral angioma both involved the distal portion of the right anterior cerebral artery. In one patient a left hemiparesis had occurred as a result of the original hemorrhage. Both were successfully demonstrated by angiography and were totally excised at craniotomy without complication or further neurologic deficit. A single patient was encountered in whom angiography showed a massive arteriovenous malformation involving almost the entire left (dominant) hemisphere and was not considered operable.

Summary

The surgical significance of subarachnoid hemorrhage has been discussed with particular attention to demonstration of specific etiology and appropriate treatment. Intracranial aneurysm constitutes a significant proportion of all subarachnoid hemorrhage and, if untreated, carries a dangerously high mortality. Direct surgical attack will save many of these patients but cannot be carried out without prompt recognition of the initial hemorrhage which is most usually first seen by the patient's personal physician. This is most readily accomplished by spinal puncture whenever such a possibility is considered. A series of fifteen intracranial aneurysms and two cerebral angiomas treated by direct attack, trapping, and in two cases by muscle wrapping has been presented. There were two operative deaths, both occurring in aneurysms of the anterior communicating artery. The series has been presented as a basis for discussion and as representative of the cases encountered in a community of this size rather than for statistical analysis.

References

1. Hamby, W. B.: Intracranial Aneurysms. p. 564, Springfield, Illinois: Charles C Thomas, 1952.
2. Mc Kissock, W., Paine, K., and Walsh, L.: Further observations on subarachnoid hemorrhage. J. Neurol. Neurosurg. Psychiat., 21:239, 1958.
3. Norlen, G., and Olivecrona, H.: The treatment of aneurysms of the circle of Willis. J. Neurosurg., 10:404, 1953.

252 E. Lovell Street

Heterohemoantibodies in Inbred Mice

Inbred mice of strains C57BL, C3H, DBA, BALB/c, and AKR bearing a variety of transplanted lymphomas, carcinomas, and sarcomas were given intraperitoneal injections of sheep or chicken red cells. Significant depression of hemolysin titers was observed in all but one group of experiments on animals with transplanted leukemias and lymphomas; this depression was less regular for agglutinin titers.

Similar depressions of immune responses to red cell antigens were demonstrated in mice with transplanted carcinomas and sarcomas given single large doses of the antigen; in mice given multiple injections of smaller amounts of red cells, differences in antibody levels between tumor-free and tumor-bearing mice were either absent or less pronounced.

Determinations of natural agglutinins for sheep red cells before and after tumor inoculation showed only exceptionally significant changes in antibody titers. These observations were compared with those reported in other investigations on related subjects and discussed with regard to possible mechanisms by means of which tumors interfere with immune responses and their potential role in the tumor-host relationship.—Kurt Stern, M.D. and Israel Davidsohn, M.D., J. Nat. Cancer Inst., 24:1319-1339, 1960.

Nursing Goals in a Psychiatric Unit Within a General Hospital

Sister Marie George, S.S.J., R.N., B.S.
William A. Scott, M.D.
Kalamazoo, Michigan

A PSYCHIATRIC unit within the general hospital is not a new discovery. As early as the seventeenth and eighteenth centuries general hospitals were treating psychiatric patients. However, shortly after admitting these patients it was realized that little could be done for them so in time these attempts were abandoned.

Now the trend is reversed, and we witness a reintegration of psychiatry in the program of the general hospital. It is being returned to its rightful place alongside such services as medicine and surgery in the general hospital.

One contributing factor toward the establishment of these units is the advance in chemotherapy. As a result, these comfortable patients are more easily managed and readily accepted within the realms of a general hospital.

Still another factor is the increased interest in mental health by the general public and their willingness to support such programs.

This response for improved care for psychiatric patients is indeed encouraging. There are over 600 general hospitals in the United States and Canada that accept and care for mentally ill patients.

The purpose of the psychiatric unit in a general hospital is to provide early and intensive treatment for emotionally disturbed patients. I say emotionally disturbed because these patients are not always psychotic, but frequently neurotic. A series of precipitating factors, causing temporary upsets, bring many patients to the hospital under the care of a psychiatrist, and consequently to the psychiatric unit. It is a known fact that the most desperate health need today is the need for facilities for acute emotional illness. The general hospital, to be worthy of its name, should be prepared to treat every type of illness and therefore should provide facilities for care and treatment of psychotic and neurotic patients. Attention must be concentrated on what can be done for patients, diagnostically and therapeutically, not just on providing a certain number of beds.

Dr. George Masters has said that "the acute General Hospital is the front line in the treatment of neuro-psychiatric diseases."[1] Thus in the fulfillment of these needs, the creation of psychiatric care in general hospitals is fruitful to the medical profession and the patient himself; the hospital becomes general in reality, when it takes care of the whole person. This unit is specifically designed for the care of those who have mental difficulties or tendencies toward them. Early recognition and preventive treatment may save years of unnecessary hospitalization.

The position of the psychiatric unit in a general hospital is within the medical department, a place where psychiatry has always belonged, but from which it has long been estranged. A psychiatric unit should not be an extraneous element engrafted on the periphery of a general hospital, but rather should be an integral part of the total hospital program. To repeat: The aim of this unit is the early diagnosis and treatment resulting in the recovery of the mentally ill patient. Psychiatric services, being included in the activities of a general hospital, have made for better understanding of mental disorders by the Physicians on the other services. The presence of the mentally ill patient in a general hospital tends to make the doctors, nurses, and the public as a whole, accept these patients as being ill. Likewise, the unit is advantageous to the medical and nursing students in clinical teaching. It emphasizes that psychiatry should be taught to students not because of the percentage of patients who are psychotic, but because the large per-



THE AUTHOR

Sister Marie George
S.S.J., R.N., B.S.

From the Borgess Hospital, Kalamazoo, Michigan.

centage of the symptoms presented by all patients will require understanding in this field.

The psychiatric unit, as a part of the general hospital, lies in the midst of the community from which its patients come. The noise and activity of community living are just beyond its doors and our desire is to return the patient as quickly as possible to take his place in its daily living. A typical psychiatric unit can accommodate the acute emergencies of the community as well as the more comfortable patients. Contact with the relatives of the patients helps to strengthen wholesome attitudes towards the emotional illness of their member. The Gray Lady Volunteer Workers not only render valuable service to the department, but also act as a liaison to the community. Through the relatives of the patients and the volunteers, we have an added opportunity to educate the public in the basic concepts of mental illness.

The psychiatric unit of Borgess Hospital was opened in July, 1957, and was gradually activated. It is referred to as Two Hundred North, just as other services are Medical, Two Hundred West, Orthopedics, Three Hundred North. Twelve psychiatrists in private practice avail themselves of this unit which is in the new wing of the hospital and will accommodate twenty-nine patients. The rooms, except for one private room, are all semi-private. The two small seclusion rooms are also single rooms which are separated from the others by an inside corridor. Oxygen is piped into each room and each is equipped with the intercommunication system. A Doctor's office, treatment room, kitchen, utility rooms, waiting room, and one large room used both for a dining room and occupational therapy room are provided. Also, there is a hydrotherapy room with one large sedative tub. The unit is situated to provide two semi-private rooms outside the locked area, and within it, the center door can be closed at the nurses' station to make two separate sections; one for the more disturbed patients and one for the more comfortable patients.

The type of psychiatric service that has developed is in keeping with "the community concept" of the large general hospital. After referral by personal physicians or other professional sources to a psychiatrist, this service offers quick hospitalization, early diagnosis, and prompt treatment of the varied types of psychiatric illnesses. Admissions to Borgess Hospital stem not only from the metropolitan area, but also from distant points of southwestern Michigan. As in other parts of the general hospital, admissions are voluntary, but committed patients are also accepted for as long as a three-month period, this being the maximum length of time our patients may remain. This insures the availability of rooms for the acute psychiatric emergencies. Alcoholic patients are admitted and cared for in the psychiatric unit if the attending medical doctor sees the need for psychiatric consultation. Among the disciplines employed in the treatment of these patients are chemotherapy, electroconvulsive therapy, psychotherapy, occupational and recreational therapy, work and bibliotherapy, plus emphasis on interpersonal relationships in this therapeutic milieu. The patients are taught sewing of every type, many crafts, including chair caning, and they make decorations and favors for the entire hospital for the holidays.

The therapeutic goal of personality integration includes the recognition of spiritual needs as well as those of body and mind. To assist with these needs, the Chaplain at Borgess Hospital is available for consultation and our patients are likewise permitted to visit the chapel located in another section of the building. The clergy of other denominations from the city visit their members regularly while they are patients in this ward.

An inservice educational program consists of weekly lectures from different staff psychiatrists with either a presentation of a case study or a discussion of some aspect of psychiatry. Psychiatric movies are shown periodically and made available to the complete general hospital staff as well as our unit. Staff conferences are also conducted weekly or as often as the need arises, wherein phases of psychiatric nursing are reviewed including medications, professional ethics, problems in the care of patients, and the allowance of time for the free ventilation of feelings and the offering of suggestions.

The ratio of trained personnel per patient fluctuates according to the census. The day shift with a full unit would vary around a 1 to 6 ratio, the evening, a 1 to 10 ratio, and on nights a 1 to 14 ratio. The personnel has shown a decided interest in psychiatry and some spend off-duty time taking patients to the recovery meetings.

Provisions for the day hospital can also be utilized on this unit. It consists of the patient arriving at 8:00 A.M. and spending the day on the ward, then going home in the evening. During this time, the patient participates in all available facilities and electric shock treatment, if indicated. In contrast to this, the night hospital is effective when the patient leaves for work in the morning and returns at night.

For the period beginning July 15, 1957, and ending

TABLE I. MENTAL DISORDERS

Acute Brain Disorders	
Acute Brain Syndrome Associated with Intoxication	
A. Alcohol Intoxication	19
B. Drug or Poison Intoxication	3
Acute Brain Syndrome Associated with Intracranial Neoplasm.	2
Chronic Brain Disorders	
Chronic Brain Syndrome Associated with Central Nervous System Syphilis With Psychotic Reaction	2
Chronic Brain Syndrome Associated with Intoxication with Psychotic Reaction	5
Psychotic Disorders	
Affective Reactions	71
Manic Depressive Reaction, Manic Type	3
Manic Depressive Reaction, Depressed Type	4
Manic Depressive Reaction, other	1
Psychotic Depressive Reaction	8
Schizophrenic Reactions	
Catatonic Type	6
Paranoid Type	9
Acute Undifferentiated Type	20
Schizo-affective Type	18
Residual Type	7
Psychoneurotic Reactions	
Anxiety Reaction	19
Conversion Reaction	4
Obsessive Compulsive Reaction	6
Psychoneurotic Reaction	19

July 15, 1959, there were 596 patients admitted for psychiatric care, a total of 12,202 patient days with the average stay per patient twenty-one days. There was a total of 1,737 E.C.T. during this period, an average of 72.4 per month. Children as young as eight years of age have been cared for in the unit, as well as people up to ninety years of age; the average age is 41.85. It is of interest to note that patients have represented nearly every profession. Of these patients, 9.56 per cent were transferred to other institutions for more definitive treatment.

The types of patients differ greatly as shown in Table I.

Various other reactions are found in smaller groups.

From our experiences with the small unit in a general hospital, we can see its great value and benefit to the community. It is designed primarily for the short-term patient. It supplies early and intensive treatment, hopefully preventing more drastic illness. It has awakened the community to the realization that physical and mental illness should merit an equal stigma. The patient's family is enlightened and we hope spreads the accepting attitude that will decrease the anxieties, fears and worries of the hospitalized mental patients. The psychosomatic influence is stressed more and more today. Nursing the whole patient includes every factor affecting him. Having psychiatry back in its place in the general hospital is more than ever giving the patient every advantage of complete care.

References

1. Masters, George: Psychiatry in the general hospital. Canad. Hosp., 34:33, 1957.

1521 Gull Road

Intensive Service Unit

A circular nurses' unit, with the rooms surrounding the central nurses' station, makes patients happier and saves time and steps for nurses, according to a study recently made at Rochester, Minnesota, by the Methodist Hospital. This information is the subject of a monograph by the American Hospital Association.

A circular unit was constructed so the nurses' station is encircled by a corridor around which there are twelve private rooms for patients. Clear glass panels in the upper halves of the double doors of each room allow nurses to observe patients from the nurses' station and the corridor. Each patient can see the nurses but not the patients in other rooms.

This grouping was checked against rectangular units with the same number of staff, of nurses, aids, patients, and similar illnesses. The universal opinion was in favor of the circular set-up. The patients felt more content, and the staff number was reduced by two.

GUEST EDITORIAL

Historical High-Spots of the Kalamazoo Academy of Medicine

Picture in your mind's eye the Kalamazoo of 1878, the year the Kalamazoo Academy of Medicine was founded. Kalamazoo at that time was proud of being the largest village in the United States, with a population of 12,000. More than 100 miles of plank sidewalk had been laid. As a matter of fact, it was said that "with addition of street railways, solid sidewalks in place of wood, and a new court house worthy of its surroundings, Kalamazoo Village would be as near perfection as any provincial town in the West."

Many attempts had been made to have a Medical Society in Kalamazoo, but all such attempts had been unsuccessful, primarily because they took in too much territory. The Kalamazoo District Medical and Surgical Association was organized February 27, 1878, with Dr. H. O. Hitchcock as President, and was incorporated in 1883 as the Kalamazoo Academy of Medicine. Twenty members comprised this organization, fifteen from Kalamazoo and one each from Vicksburg, Alamo, Galesburg, Climax and Richland.

* * *

THE ORIGINAL RECORDS of the Academy state that "any legally qualified physician or surgeon who does not subscribe to, nor practice according to any exclusive dogma of medical practice, may become a member of this Academy XXXX." Exactly what was meant by a "legally qualified physician" is not known, since it is a matter of history that prior to 1883 there was no legislative restriction to the practice of medicine in Michigan. It is interesting to note that an initiation fee of $2.00 was required in joining the Academy, and that the annual dues "shall be one dollar each, or such a sum, not exceeding three dollars, as shall be ordered at the annual meeting."

On July 29, 1884, it was decided that "the seal of the Academy shall consist of a representation of a compound microscope and an open book leaning against the same, resting upon the year of our incorporation, in Roman numerals, all being surrounded by a band bearing the words, Kalamazoo Academy of Medicine."

The second President of the Academy was Dr. E. B. Dunning and the third President was Dr. Edwin H. VanDeusen, who then lived in Otsego.

On January 31, 1893, Dr. and Mrs. VanDeusen presented to the Kalamazoo Board of Education, a sum of $50,000 for the erection of a Public Library building, stipulating that a "commodious room with a small office attached, be permanently set apart for the exclusive use of the Kalamazoo Academy of Medicine." On May 29, 1893, meeting for the first time in the Public Library building, the Kalamazoo Academy of Medicine accepted from Dr. and Mrs. Van Deusen "with profoundly grateful thanks, their noble gift to us of assembly and committee rooms, fully and elegantly furnished and equipped for use."

The Academy continued to use this meeting place until 1957 when the building was demolished. On the same site, in 1959, a new Public Library was completed. The new auditorium on the second

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floor is appropriately named "The VanDeusen Auditorium" and, until 1969, the Academy will be privileged to use this auditorium without charge.

* * *

TO READ THE MINUTES of the Academy meetings throughout the years is to read medical history in a local setting. I found that new drugs, instruments and procedures were reported locally at the same time or soon after their discovery. The thoughts, work and beliefs of many really great local M.D.s have been recorded in the records of the Academy. One of these, Dr. August W. Crane, was elected a member of the Kalamazoo Academy on November 13, 1894, and gave his first paper entitled "New Chapters on the Biology of the Blood" at the Academy Meeting in July, 1897. Dr. Crane was a pioneer in the development of the x-ray as applied to Medicine. He won high honor for himself and brought prestige to the Kalamazoo Academy of Medicine and the City of Kalamazoo. Each February, for the past 20 years, the "Crane Memorial Lecture" has become traditional in Academy programs.

In 1900, at which time the Academy listed 46 members, meetings were held at 2:00 p.m. in the Academy rooms. At one of the meetings during that year, the "crowded conditions of the hospitals" was discussed, but obviously the problem was not settled, since it still exists today.

* * *

THE RECORDS OF the Academy show that in 1902 the usual fee for a day house call was $1.50, a night house call was a dollar more and office calls were $.75 and up. During that same year, at a special meeting on July 1, 1902, the Academy officially associated itself with the Michigan (State) Medical Society.

In 1909, when the Kalamazoo Academy of Medicine embraced Kalamazoo, Allegan, and Van Buren Counties, a new constitution was written. Annual dues at that time were $3.50.

The first record I could find of a combined meeting of the Kalamazoo doctors and their wives was on August 25, 1914. This meeting was held at Gull Lake and the ladies prepared the program. Mrs. O. H. Clark gave a paper on "Mothers as Suffragists"; Mrs Bartlett Crane gave a paper on "Community Hygiene"; and Dr. Bertha VanHoesen, Chicago, gave a paper on "Twilight Anesthesia." The program and the day in general were considered a complete success. During more recent years, combined meetings have traditionally been held in June and at Christmas time.

By 1913 the annual dues were increased to $4.00 for local members and $5.00 for non-resident members. During this period, regular meetings of the Academy were held in Allegan, South Haven, and Otsego, as well as Kalamazoo.

As the years passed, the attendance at Academy meetings gradually increased. The first evidence that the Academy rooms were too small is noted in the record of March, 1915, when the meeting was held in the Auditorium of the Burdick House. At this meeting Dr. William Mayo spoke on "Some General Considerations Which Influence the Advisability of Surgical Treatment," a meeting which attracted 185 people.

* * *

WAR CLOUDS WERE ALREADY gathering over Europe during these years and the Academy of Medicine (still embracing Kalamazoo, Allegan and Van Buren Counties) supplied 27 doctors during World War I. Twelve of these men who wore the caduceus on their uniforms were from Kalamazoo and fortunately there were no casualties.

It was my good fortune while a student in 1919, to obtain part-time employment at the Colman Drug Co. This store was frequented by most of the physicians of Kalamazoo and surrounding territory. I recall the abrupt manner of Dr. Paul T. Butler. I remember, too, the ruddy complexion of Dr. Dan Eaton, and the prematurely gray hair of Dr. John T. Burns when he returned from service in World War I. I remember Dr. Bartholomew coming in from Martin. The bellowing voice of Dr. Don P. Osborne, I was told, was only a thin veneer covering a heart of gold. I remember Dr. Arthur E. West, with his neatly trimmed beard and his fine physique. I remember, too, when a tall thin young medic came to Kalamazoo to start practice—Dr. Reader J. Hubbell had the respect and admiration of the entire membership of the Kalamazoo Academy of Medicine long before he became President of the Michigan State Medical Society. Dr. Hubbell was the fifth Kalamazoo man named as President of our State Society. In 1871 Dr. H. O. Hitchcock was President and in 1877 Dr. Foster Pratt was President for the State Society. Both of these men were charter members of the Kalamazoo Academy of Medicine. Dr. Herman Ostrander in 1907 and Dr. John B. Jackson in 1926, were also Presidents of the Michigan State Medical Society.

Evening meetings of the Academy were tried in February, 1920, but were not routine until October, 1922. On September 25, 1923, it was decided to have only one Academy Meeting a month instead of two.

* * *

IN 1927, THROUGH the efforts of Dr. Caroline Bartlett Crane, the Woman's Auxiliary to the Kalamazoo Academy of Medicine was organized, with 35 charter members. The objectives of the Auxiliary have been carried out to the fullest extent during the past 33 years and the Academy is, and should be, grateful to the Auxiliary for its many successful accomplishments.

That year of 1927, the Academy numbered 120 active and 8 associate members. The Secretary gave

a résumé of the year in his annual report published in the December Bulletin, and I quote "the past year has been an unusually prosperous and happy one for the Kalamazoo Academy of Medicine. The spirit of harmony has prevailed and it is hoped that the spirit may be fostered throughout the years to come. Live speakers and excellent programs have been an irresistible drawing card contributing their full share to the excellent attendance record for the year. The angel of death has passed us by; none have moved from our midst; and only one of our former members has deemed the society unworthy of the payment of dues."

All of us vividly recall Pearl Harbor Day, December 7, 1941. The ensuing events resulted in the donning of uniforms by 49 Academy members (which no longer included Van Buren and Allegan Counties) during World War II. There were 2 local casualties, Dr. Charles E. Osborne of Vicksburg and Dr. Isaac N. LaVictoire of the Kalamazoo State Hospital. Most of the local medics had returned by June, 1946, at which time there was a total of 152 physicians working or residing in Kalamazoo. Annual dues of $52.00 caused a few complaints which were completely ignored by the Treasurer. The dues were increased to $67.00 by 1949 and are now $140.00 annually.

* * *

IT WAS FASCINATING reading and thumbing through the old records of the Academy. I am grateful for the legibility of these records as they were written in long hand over many years. It has been a problem to choose what was most important as the years progressed, so that this paper might not become too lengthy. In a few instances it was necessary to choose which authority was most likely to be correct, when conflicting reports were made. I might tell you, for instance, that Dr. Alvin H. Rockwell was the first Kalamazoo doctor to drive an automobile. This is so reported in the "In Memoriam" for Dr. Rockwell, as published in the Academy Bulletin of June 17, 1941. In his "medical memoirs," on page 85, Dr. Rush McNair states that Dr. Edward Ames was the first Kalamazoo doctor to drive a car. I have no way of knowing which report is the more accurate.

I feel certain that the Kalamazoo Academy of Medicine will continue to thrive in the future and that the members of the Academy will continue to uphold the ideals upon which our organization was founded 82 years ago.

G. H. RIGTERINK, M.D.

* * *

Our thanks go to Robert D. Warnke, M.D., Secretary of the Kalamazoo Academy of Medicine, for his splendid co-operation and assistance in securing the very fine collection of papers appearing in this issue which is dedicated to the Kalamazoo Academy of Medicine.

MMS Requested Rate Increase Again Reduced

It was reported editorially in the July issue of THE JOURNAL that Blue Shield had asked the State Insurance Commissioner for a premium rate increase of 19½ per cent. The Board had considered this decision over a long period of time and was finally forced to make the request in spite of political and other compelling considerations. The utilization of the plans, the unexpectedly large increase in cases coming to the doctors and hospitals, and the constantly increasing costs in caring for these cases were using up not only the reserves of Michigan Medical Service, but threatening the money needed for current expenses. These two items plus an actuarial misconception of the costs: the rates established had been intended to cover at least two years but in the first year of actual usage proved inadequate. In the July issue, we published information and letters to our membership explaining the situation and announcing the appeal to the Insurance Commissioner.

* * *

HEARINGS WERE HELD in Grand Rapids and in Detroit which our MSMS officers attended and in which they testified giving details and information, and answering questions. The Commissioner took the matter under advisement until June 15 when he announced his decision. He disapproved building up the reserve as much as actuaries had advised. He allowed an 11.5 per cent increase instead of 19.5 per cent and announced that this was to hold for one year—saying that this would give Blue Shield a breathing period in which to develop a more stable rate and benefit structure.

Mr. Blackford said, "There is no use attempting to gloss over the precarious financial situation of Blue Shield—our choice was between approving an adjustment in rates or permitting the program to go down the drain. We could not let that happen. I am sure the majority of subscribers will approve."

* * *

THE COMMISSIONER ordered Blue Shield Board of Directors to take steps before next July to establish a plan to prevent "abuse or misuse" of medical insurance. He said the Insurance Department has received complaints that some doctors charge Blue Shield subscribers higher fees than other patients, bill Blue Shield for services never performed, and make Blue Shield pay for the excessive number of diagnostic services. "The public is more than willing to pay for adequate medical care but they do object to subsidizing abuses or misuse."

In granting only 11.5 per cent premium increase, Mr. Blackford said he was disallowing Blue Shield's plea for 3.5 per cent additional money to build up a surplus for future emergencies, or to help Blue Shield

recoup the approximately $4 million it would be in the red by June 30, 1960. THE JOURNAL has given the high points of this decision, not all the details. The medical profession and Michigan Medical Service are on trial in Michigan, but that trial is not confined to Michigan. The major part of the considerations, conferences, actions, etc., of the American Medical Association in Miami at the June, 1960, Annual Session was devoted to prepayment health insurance and old age care. Everybody in authority and experience expressed the belief and the hope that Blue Shield and the pre-payment concept could survive these trying times. Never before has the American Medical Association through its top officials expressed so much concern as they do now to preserve the private practice of medicine—independent from government dictation.

Use, Not Abuse

Recently the American Medical Association published a little two-color booklet *Let's Use, Not Abuse Health Insurance*. Every doctor should have copies on his desk where his patients could take one. They are free. We quote the last two paragraphs.

> "If everyone with a stake in the success of voluntary insurance accepts his personal responsibility for making these plans work, the end result will be continually improved insurance plans more closely tailored to your own family's financial needs.
>
> "And like the family car that's well cared for, you'll get a lot more mileage out of your health insurance coverage if you use it, not abuse it."

Several points of abuse most of our doctors know: there is the insured person who wishes to get full benefit of everything he thinks he is entitled to (the limit) because he has paid his premium. He asks for too many services not intended to be covered by the contract. Also there is the doctor who readily sends his patient into the hospital for diagnosis not covered, rather than for treatment of a diagnosed condition. There is the hospital which wishes its beds to be used continuously and welcomes an extra day's stay for patients. There is the doctor who in writing his orders, and in treating his patients, has unnecessary services performed, even has standing orders in the hospital for minor or elaborate preparatory surveys before he even sees the patient.

Medical Expenditures

In the opinion of a great majority of our critics, the doctor is accused of unnecessarily benefiting, or of having extra or more expensive work done. Surveys of the dollar spent for all health service are being mentioned in every cost of living increase being reported by the federal government. The doctor's share of that dollar is being constantly decreased.

Only five years ago it was 37 cents, today it is less than 24 cents, but that medical dollar is ballooning in many ways to fabulous figures. The reasons—hospital care and hospital services have been improved and increased enormously, the costs naturally going up because they are mostly labor. Services for many of the individual conditions or the specific conditions have been undergoing rapid change. Research has produced new drugs and new methods, many of which are costly, the result being that the total cost of any mentioned service has just about doubled in the last four or five years. Many new and unusual services were unknown five years ago and the costs are high. What shall we do?

There are medical care insurance committees in every Councilor District of the state who have an advisory and consultive capacity with authority. They should be consulted wherever there is a question of proper procedures or proper services or adequate compensation. It may be necessary for that committee even to make surveys of our hospitals to determine just who among our members is ordering the unnecescary blood count, EKG, GI series, electrocardiogram or what have you. Every member, whenever he is taking care of a patient under Blue Shield contract, should ask himself one question: "Have I given this patient adequate care without unnecessary expense?" If that could be done, there should be no fear for the future of Blue Shield and we believe such a demonstration would earn for Michigan Medical Service the increased rating necessary to keep the program in the black.

It may be necessary, and this has been considered by the Board, to withhold percentage of the payment due the doctors. Nineteen years ago Blue Shield "prorated" 20 per cent for enough time to get back on a financial balance. Three or four years later that proration was all returned to the doctors. The Board hopes it will not be necessary to withhold this time—but that may be the only alternative. There is a strong sentiment in our Board, also in the Blue Shield programs in other states, that during this crisis (which is not local to Michigan), the doctors' fees not be cut but a percentage be withheld if necessary with the understanding that it is to be repaid when and if the program can police itself, prevent abuses and again be solvent.

Many Thanks

We wish to express our sincere thanks to Robert D. Warnke, M.D., of Kalamazoo, for his invaluable assistance in securing the many fine original papers which are published in this special issue of THE JOURNAL devoted to the Kalamazoo Academy of Medicine.

Michigan State Medical Society

The Ninety-Fifth Annual Session

SHERATON-CADILLAC HOTEL, DETROIT

September 25-30, 1960

Meetings of Special Societies and Sections

TUESDAY, SEPTEMBER 27

MSMS Section on Medicine and Michigan Society of Internal Medicine—5:00-6:00 p.m. Section meeting followed by reception and dinner at 6:30 p.m. in Suite 610 of the Sheraton-Cadillac Hotel.

AMERICAN ACADEMY OF PEDIATRICS

Michigan Chapter

Annual Meeting—September 27, 1960—Detroit

Henry Ford Hospital-Clinic Building Auditorium

Morning Session

DR. PHILIP J. HOWARD, Presiding

Case Presentations and Discussion

A.M.

10:00 Adenoma of the Thyroid—DR. MARTIN MILLER
10:30 Intersex Problems of the Newborn Infant—DR. C. PAUL HODGKINSON
11:00 Aldosteronism—Clinical Description and Course—DR. RAYMOND MELLINGER
11:30 The Infant of the Diabetic Mother—DR. GORDON MANSON

M.

12:00 The Parathyroid—DR. BOY FRAME

P.M.

12:45 LUNCH—17th Floor

Afternoon Session

DR. ROBERT HEAVENRICH, Presiding

2:00 Turner's Syndrome—DR. RICHMOND SMITH
2:30 Adolescent Menstrual Problems—DR. GEORGE LACROIX
3:00 Treatment of Hyperthyroidism—DR. ROBERT BAUER
3:30 The Complications of Steroid Treatment—DR. J. A. JOHNSTON

Evening Session

Pan American Room—Sheraton-Cadillac Hotel

6:00 Cocktails and Dinner
Host—The Baker Laboratories, Cleveland, Ohio
8:00 Evening Meeting
Business—Election of Officers
Speaker—DR. ROBERT BLIZZARD—Columbus, Ohio, and Johns Hopkins Medical School

Michigan Academy of Physical Medicine and Rehabilitation—The annual meeting will be held in the Pan American Room of the Sheraton-Cadillac Hotel from 12:30 p.m. until 2 p.m., Tuesday, September 27. The meeting will be a business luncheon meeting and will be open only to members of the Michigan Academy of Physical Medicine and Rehabilitation.

WEDNESDAY, SEPTEMBER 28

MSMS Section on Obstetrics-Gynecology and the Michigan Society of Obstetrics-Gynecology—5:00-6:00 Section meeting followed by reception and dinner at 6:30 p.m. in the English Room of the Sheraton-Cadillac Hotel.

Michigan Allergy Society—6:00 p.m. reception and dinner followed by a meeting at 8:30 p.m. in Parlors G-H-I of the Sheraton-Cadillac Hotel.

Michigan Regional Committee on Trauma, American College of Surgeons—12:00 noon luncheon followed by a 2:00-5:00 p.m. meeting. Luncheon will be in the Sheraton Room and the meeting is scheduled for Parlors G-H-I of the Sheraton-Cadillac Hotel.

Michigan Society of Clinical Hypnosis—8:00 p.m. meeting in the Sheraton Room of the Sheraton-Cadillac Hotel.

Detroit Pediatric Society—Reception and dinner in the Grand Ballroom of the Sheraton-Cadillac Hotel.

MSMS Advisory Committee of Past Presidents—12:00 noon luncheon-meeting in Parlor F of the Sheraton-Cadillac Hotel.

THURSDAY, SEPTEMBER 29

Association of Alpha Kappa Kappa—7:30 a.m. breakfast and meeting in the Pan American Room of the Sheraton-Cadillac Hotel.

MSMS Section on Nervous and Mental Diseases, the Michigan Society of Neurology and Psychiatry, and the Michigan District Branch of the American Psychiatric Association—5:00-6:00 p.m. Section meeting followed by reception and dinner at 6:30 p.m. in the English Room of the Sheraton-Cadillac Hotel.

MSMS Section on Otolaryngology and the Detroit Otolaryngological Society—5:00-6:00 p.m. Section meeting followed by reception and dinner at 6:30 p.m. in the Sheraton Room of the Sheraton-Cadillac Hotel.

Wayne State University College of Medicine Alumni Association—will hold an annual banquet in the Book Casino Room of the Sheraton-Cadillac Hotel. Reception and cocktails at 6:00 p.m. and dinner at 7:00 p.m. All alumni, faculty, and friends of Wayne State University are cordially invited to attend. Dean Gordon H. Scott of the College of Medicine will be the principal speaker. The College of Medicine Alumni Association will also maintain a headquarters suite in the Sheraton-Cadillac Hotel during the Annual Session.

THURSDAY, SEPTEMBER 29 *(continued)*

Michigan Diabetes Association—6:30 p.m. reception-dinner, Bagley Room, Statler-Hilton Hotel. Talk on "Specific Vascular Lesions in the Diabetic" by Sidney Goldenberg, M.D., Senior Instructor in Medicine, St. Louis University School of Medicine, St. Louis, Missouri.

FRIDAY, SEPTEMBER 30

MSMS Section on Gastroenterology and Proctology—1:00 p.m. luncheon and Section meeting in the Pan American Room of the Sheraton-Cadillac Hotel.

MSMS Section on Pathology and Michigan Pathological Society—12:30 p.m. luncheon-meeting with Assembly speaker R. Dorothy Sundberg, M.D., Minneapolis, Minnesota, in the English Room of the Sheraton-Cadillac Hotel.

MICHIGAN DIABETES ASSOCIATION

Grand Ballroom

Sheraton-Cadillac Hotel—Detroit

Chairman: RALPH FITTS, M.D., Grand Rapids, Michigan

P.M.

2:00 "Physiology of Diabetes"—ROBERT B. LEACH, M.D., Assistant Professor of Medicine, Wayne State University College of Medicine, Detroit

2:20 "Pathology of Diabetes"—JOHN R. McDONALD, M.D., Associate Professor of Pathology, Wayne State University College of Medicine, Detroit

2:40 "Modern Insulin Therapy"—HENRY T. RICKETTS, M.D., Professor of Medicine, University of Chicago School of Medicine, Chicago, Illinois

Intermission

3:20 "Oral Drugs in Diabetes"—JAMES M. MOSS, M.D., Clinical Associate Professor of Medicine, Georgetown University School of Medicine, Washington, D. C.

3:40 "Clinical Use of Glucagon"—FRED W. WHITEHOUSE, M.D., Associate Physician, Henry Ford Hospital, Detroit

4:00 PANEL: "Peripheral Vascular Disease in the Diabetic"

Moderator:

WALTER L. ANDERSON, M.D.—Clinical Assistant Professor of Medicine, Wayne State University College of Medicine, Detroit

Members:

HENRY T. RICKETTS, M.D.—Chicago
EUGENE A. OSIUS, M.D.—Clinical Associate Professor of Surgery, Wayne State University College of Medicine, Detroit
MELVIN A. BLOCK, M.D.—Associate Surgeon, Henry Ford Hospital, Detroit
SIDNEY GOLDENBERG, M.D.—Senior Instructor in Medicine, St. Louis University School of Medicine, St. Louis, Missouri

THE WOMAN'S AUXILIARY TO THE MICHIGAN STATE MEDICAL SOCIETY will hold its Annual Session this year at the Pick-Fort Shelby in Detroit, September 27-29. For the Auxiliary this will be the thirty-fourth year, the ideal age of woman, and the Auxiliary officers hope all wives and guests of doctors attending the MSMS Annual Session will find their way to the W. A. center of activity.

Here will be opportunity for renewing friendships of the past and making new and exciting ones. Here one can learn what is being done around the state by other doctors' wives. There will be coffee and refreshments for all in our hospitality room; delicious luncheons at noon.

Come Tuesday, register and make your reservations, then spend the day shopping. Stay Wednesday for excitement and information in the meetings. Thursday, your new officers will be installed and there will be more shopping time in the afternoon before celebrating State Society Night with your husband.

In honor of Kathleen Mackersie, Michigan's First National President, the WA officers hope you will come and help make this convention the biggest gala event in the history of the Auxiliary! You really can't afford to miss it!

WOMAN'S AUXILIARY, MICHIGAN STATE MEDICAL SOCIETY

Thirty-fourth Annual Meeting

September 27-29, 1960

Pick-Fort Shelby — Detroit

PROGRAM

Tuesday, September 27

P.M.

12:00 Registration in Lobby, Pick-Fort Shelby
Hospitality Room Opens
Luncheon—Shelby Room—Planning Conference for District Directors 1959-60 and 1960-61
MRS. CLARENCE OWEN, Presiding

3:00 Executive Committee Meeting—Shelby Room

4:00 Meeting of 1959-60 and 1960-61 Committee Chairmen—Shelby Room

Wednesday, September 28

A.M.

9:30 Pre-Convention Board Meeting (for 1959-60 State Officers, Directors, Chairmen and County Presidents)—Crystal Ballroom

10:00 Formal Opening of 34th Annual Meeting of the Woman's Auxiliary to the Michigan State Medical Society—Crystal Ballroom
MRS. HAROLD GAY, Presiding

(Delegates and Board Members will please register with the Roll Call Chairman at the door before the opening of each session, thus eliminating the need of an oral roll call.)

Invocation—BISHOP R. S. EMERICH, St. Pauls Cathedral, Detroit

Pledge of Allegiance to the Flag and Woman's Auxiliary Pledge—MRS. ROBERT HAFFORD

Address of Welcome—MRS. EARL WESTON, Immediate Past President, Wayne County Auxiliary

Response—MRS. CLARENCE OWEN, First Vice-President, Woman's Auxiliary to the Michigan State Medical Society

Introduction of Convention Chairmen, MRS. F. P. RHOADES and MRS. EDWIN FENTON

Report of Roll Call Chairman, MRS. FREDERICK LUGER
Convention Rules of Order
Presentation of Program
Announcements
Address of the President—MRS. HAROLD H. GAY

Reports of the Officers:
President-Elect—MRS. PAUL IVKOVICH
First Vice-President—MRS. CLARENCE OWEN
Second Vice-President—MRS. ROSE TAYLOR
Recording Secretary—MRS. WILLIAM MARSHALL
Corresponding Secretary—MRS. G. L. HAGELSHAW
Financial Secretary—MRS. C. J. STRINGER
Treasurer—MRS. R. J. HIMMELBERGER (including the Auditor's report)

Report of the Finance Committee and presentation of 1960-61 budget—MRS. F. X. KRYNICKI, chairman
Unfinished Business
New Business

P.M.

12:30 Past President's Luncheon—Honoring:
MRS. WILLIAM MACKERSIE, President Woman's Auxiliary to the AMA, Guest from Woman's Auxiliary to the AMA, Past President of the Woman's Auxiliary to the MSMS and Representatives of the MSMS
Coral Room—Pick-Fort Shelby
Greetings—KENNETH JOHNSON, M.D., President-Elect MSMS
DAVID I. SUGAR, M.D.,
President Wayne County Medical Society
(Name to be announced)
Representative from Woman's Auxiliary to AMA
Guest Speaker—MRS. ELEANOR BROWN, Interior Designing Lecturer, Toronto, Canada

2:30 Resume General Session
Crystal Ballroom
Address—Representative from Woman's Auxiliary to AMA
County Reports—"THE YEAR IN SILHOUETTE"
District I—Moderator—MRS. MILTON WEED
Huron, Lapeer, Macomb, Oakland, Sanilac, St. Clair, Wayne
District II—Moderator—MRS. VICTOR ZERBI
Eaton, Ingham, Jackson, Lenawee, Livingston, Monroe, Washtenaw
District III—Moderator—MRS. ALBERT FIEGEL
Allegan, Berrien, Branch, Calhoun, Kalamazoo, St. Joseph, Van Buren

Thursday, September 29

A.M.

8:00 Memorial Breakfast
In Memoriam Service—MRS. C. ALLEN PAYNE

9:30 General Meeting of the Woman's Auxiliary to the Michigan State Medical Society—MRS. HAROLD GAY, *presiding*
Convention Announcements
Report of Registration and Credentials Committee

County Reports *(continued)*

District IV—Moderator—MRS. LORENZO NELSON, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo
District V—Moderator—MRS. WILLIAM GAMBLE, JR., Bay, Genesee, Gratiot-Isabella-Clare, Clinton, Midland, Saginaw, Shiawassee, Tuscola

District VI and VII — Moderator — MRS. CHARLES OPPY, Grand Traverse-Leelanau-Benzie, North Central, Northern Michigan, Wexford-Missaukee
District VIII and IX — Moderator — MRS. LEONARD ALDRICH, Delta-Schoolcraft, Dickinson-Iron, Marquette-Alger, Menominee, Houghton-Baraga-Keeweenaw, Gogebic, Ontonagon, Chippewa

Report of Resolutions Committee
Report of Nominating Committee—MRS. ROBERT REAGAN, *Chairman*

Election of Officers

Final Report of Registration and Credentials Committee

Meeting of Executive Committee 1960-61—MRS. PAUL IVKOVICH, *presiding*

P.M.

12:30 Inaugural Luncheon—Coral Room, Pick-Fort Shelby Hotel

Installation of Officers

Presentation of Past President's Pin—MRS. ROBERT REAGAN

Inaugural Address—MRS. PAUL IVKOVICH

Adjournment

Post-Convention Board Meeting for all 1960-61 Officers, District Directors, Chairmen, and County Presidents—immediately following adjournment of Annual Meeting
Coral Room—Pick-Fort Shelby Hotel
MRS. PAUL IVKOVICH, *presiding*

P.M.
9:30 to 12:30 **A.M.** State Society Night
Host—Michigan State Medical Society

NEW INFORMATION IN THE EXHIBIT

Many items of interest or education will be found in the large exhibit of 95 technical displays. The Exhibit Section at MSMS Annual Sessions is as important, informative, and desirable to most doctors of medicine as the scientific papers presented in the Assembly room.

Doctor, stop at every booth—you'll be surprised how much you'll learn. No highpressure salesman but a courteous, well-informed exhibitor will greet you and supply you with some valuable information helpful to your patients.

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Annual Meeting Program

September 28-29, 1960

Statler-Hilton Hotel, Detroit

Tuesday, September 27

P.M.

7:00 Hospitality Room
Welcoming Committee
Hostess: Miss Babs Ball, President, Detroit Medical Assistants Society

Wednesday, September 28

A.M.

9:00 Mezzanine
Registration—Fee for non-members $5.00
Co-Chairmen: Virginia Miller and Virginia Stewart

10:00 Bagley Room
Welcome—Mrs. Reta Stahl, President, MSMAS
Pledge and Invocation—Hallie Cummins
Annual Business Meeting and Election of Officers
Parlor F
Film for Non-Members
"Socialized Medicine in Britain"

P.M.

12:30 Wayne Room
Luncheon
Hostess: Mrs. Nelda Gasperson
Speaker: E. A. Irvin, M.D., Medical Director Ford Motor Company
"Motives and Incentives"

2:00 Bagley Room
Willard Dickerson, M.D., Superintendent Caro State Hospital for Epileptics
"Temporal Lobe Seizures"

3:00 Movie—"Seizures," Courtesy, Parke-Davis & Co.

4:00 View Exhibits—Sheraton-Cadillac Hotel

6:30 Bagley Room
Social Hour—Courtesy, Parke-Davis and Co.
Hostess: Mrs. Thelma Cousineau
Toni Patti—The Wandering Minstrel

7:30 Wayne Room
Banquet
Hostess: Miss Gwen Whitcomb
Dinner Music—Toni Patti
Speaker: Mr. Wilfred Holmes-Walker, Rector, St. Phillips and St. Stevens Church
"Religion and Health"

Thursday, September 29

A.M.

9:00 Mezzanine
Registration—Fee for non-members $5.00

10:00 Bagley Room
Joseph Molner, M.D., Detroit Board of Health
"Preventative Medicine and Vaccines"

11:00 Stuart Finch, M.D., Associate Professor of Psychiatry, University Hospital, Ann Arbor
"Adolescent Problems"

P.M.

12:30 Wayne Room
President's Luncheon
Hostess: Miss Dottie DeYoung
Installation of Officers
J. L. Hudson Company Uniform Style Show

2:30 Tour—approximately two hours
Chairman: Mary Jayne Baker

4:00 View Exhibits—Sheraton-Cadillac Hotel

MSMAS Officers

President—Mrs. Reta V. Stahl, 308 S. Superior, Albion

President-Elect—Mrs. Betty Lou Willey, 1108 Military, Port Huron

Recording Secretary—Miss Catherine La Pres, 302 Medical Arts Center, Muskegon

Corresponding Secretary—Mrs. Nan Globensky, Sheldon Memorial Hospital, Albion

Treasurer—Miss Cecile Rutan, Hanover, Michigan

Past-President—Miss Donna Hislop, 878 Second Street, Muskegon

Historian—Mrs. Catherine Fuller, 121 S. Main Street, Olivet

MSMS Advisory Committee

John W. Rice, M.D., Chairman, Jackson

L. E. Holly, II, M.D., Muskegon

D. B. Johnson, M.D., Lansing

J. E. Manning, M.D., Saginaw

G. E. Millard, M.D., Detroit

A. S. Narotsky, M.D., Ishpeming

T. J. Trepasso, M.D., Sault Ste. Marie

J. A. Witter, M.D., Highland Park

Ralph Carlson, M.D., Iron Mountain

Committees

Convention: Miss Esther Bartlet, Co.-Chairman, Detroit
Mrs. Cora Steckel, Co.-Chairman, Detroit

Nominating: Mrs. Gertrude Haessig, Schoolcraft

Public Relations: Mrs. Beth Brinn, Saginaw

Membership: Mrs. Alta Greene, Battle Creek

Education: Mrs. Marguerite Woolhouse, Lansing

Civil Defense: Mrs. Lorine Luplow, Saginaw

Bulletin Editor: Miss Marie Erickson, Saginaw

Circulation: Miss Helen Hawkins, Saginaw

Business Manager: Mrs. Altha Kaunitz, Bay City

Educational Seminar: Mrs. Marion Collins, Jackson

November President's Conference: Mrs. Kay Wilcox, Bay City

April President's Conference: Mrs. Violet Howorth, Benton Harbor

Medical Assistant of the Year: Mrs. Carol Anderson, Coldwater

Constitution: Miss Hallie Cummins, Caro

Budget Committee: Miss Cecile Rutan, Hanover

U.P. Representative: Mrs. Jean P. Carey, Marquette

IT'S NEW AND IT'S ALL FOR YOU

"State Society Dinner Dance"

Thursday, September 29, 1960

Sheraton-Cadillac Hotel

Detroit

All MSMS members and their ladies are invited to the "State Society Dinner Dance" for an evening of fun and merriment. Also attending the colorful social event will be the Annual Session exhibitors. This new event combines the former "gridiron banquet" for the exhibitors, the Officers Night Dinner Dance and the State Society Night.

You're invited to join the group for preprandials, followed by an evening of dinner, dancing and a stellar floor show.

The tickets will be limited, so you are urged to take advantage of the advance reservation form which will be sent soon to every member.

Remember, you are invited to this delightful evening.

IT'S NEW AND IT'S ALL FOR YOU

OUTLINE OF 1960 ASSEMBLY AND SECTION SPEAKERS
95TH ANNUAL SESSION MSMS
Detroit, September 27-28-29-30, 1960

Tuesday
September 27, 1960

Registration
begins at 10:00 a.m.
on Tuesday

2:00-2:30 p.m.
Medicine
HUGH R. BUTT, M.D.
Rochester, Minnesota

2:30-3:00 p.m.
Medicine
JOHN B. GROSS, M.D.
Rochester, Minnesota

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Medicine
HENRY J. TUMEN, M.D.
Philadelphia, Pennsylvania

4:30-5:00 p.m.
Public Health & Preventive Medicine
MALCOLM H. MERRILL, M.D.
Berkeley, California

5:00 p.m. meeting-dinner
Section on Medicine and Michigan Society of Internal Medicine
WM. D. ROBINSON, M.D.
Ann Arbor, Michigan

5:00-6:00 p.m. meeting
Section on Public Health & Preventive Medicine
MALCOLM H. MERRILL, M.D.
Berkeley, California

5:00-6:00 p.m. meeting
Section on General Practice
JOHN B. GROSS, M.D.
Rochester, Minn.

Wednesday
September 28, 1960

9:00-9:30 a.m.
Obstetrics-Gynecology
J. ROBERT WILLSON, M.D.
Philadelphia, Pennsylvania

9:30-10:00 a.m.
Obstetrics-Gynecology
ROBERT H. BARTER, M.D.
Washington, D. C.

10:00-11:0 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Obstetrics-Gynecology
ROY G. HOLLY, M.D.
Omaha, Nebraska

11:30 a.m.-12:00 M
Radiology
RUTH J. GUTTMANN, M.D.
New York, New York

12:00-12:30 p.m.
Surgery
ROBERT TURELL, M.D.
New York, New York

12:30-2:00 p.m.
Luncheon

2:00-3:00 p.m.
Surgery Panel
CHARLES G. CHILD, 3RD, M.D.
Ann Arbor, Michigan
BENTLEY P. COLCOCK, M.D.
Boston, Massachusetts
GORDON A. DONALDSON, M.D.
Boston, Massachusetts

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-4:30 p.m.
Surgery
GERALD O. MCDONALD, M.D.
Chicago, Illinois

4:30-5:00 p.m.
Anesthesiology
JOHN J. BONICA, M.D.
Tacoma, Washington

5:00-6:00 p.m. meeting
Section on Surgery
CHARLES G. CHILD, 3rd, M.D.
Ann Arbor, Michigan

5:00 p.m. meeting-dinner
Section on Obstetrics-Gynecology and Michigan Society of Obstetrics-Gynecology
ROY G. HOLLY, M.D.
Omaha, Nebraska

5:00-6:00 p.m. meeting
Section on Radiology
RUTH J. GUTTMANN, M.D.
New York, New York

5:00-6:00 p.m. meeting
Section on Anesthesiology and Michigan Society of Anesthesiology
JOHN J. BONICA, M.D.
Tacoma, Washington

Thursday,
September 29, 1960

9:00-10:00 a.m.
Dermatology-Syphilology Panel
CLARENCE S. LIVINGOOD, M.D.
Detroit, Michigan
RUDOLF L. BAER, M.D.
New York, New York
DONALD J. BIRMINGHAM, M.D.
Cincinnati, Ohio

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00-11:30 a.m.
Ophthalmology
ROBERT W. HOLLENHORST, M.D.
Rochester, Minnesota

11:30 a.m.-12:00 M.
Otolaryngology
JOHN J. CONLEY, M.D.
New York, New York

12:00-12:30 p.m.
Urology
HARRY M. SPENCE, M.D.
Dallas, Texas

12:30-2:00 p.m.
Luncheon

2:00-3:00 p.m.
Urology-Pediatric Panel
HARRY A. TOWSLEY, M.D.
Ann Arbor, Michigan
MITCHELL I. RUBIN, M.D.
Buffalo, New York
VINCENT J. O'CONOR, M.D.
Chicago, Illinois

3:00-4:00 p.m.
INTERMISSION TO VIEW EXHIBITS

4:00-5:00 p.m.
Occupational Medicine and Nervous and Mental Disease Panel
LEONARD E. HIMLER, M.D.
Ann Arbor, Michigan
R. LOMAX WELLS, M.D.
Washington, D. C.
RALPH T. COLLINS, M.D.
Rochester, New York

5:00 p.m. dinner-meeting
Section on Nervous and Mental Diseases and Michigan Society of Neurology and Psychiatry
RALPH T. COLLINS, M.D.
Rochester, New York

5:00-6:00 p.m. meeting
Section on Pediatrics
REED M. NESBIT, M.D.
Ann Arbor, Michigan

5:00 p.m. meeting-reception
Section on Occupational Medicine
R. LOMAX WELLS, M.D.
Washington, D. C.

5:00-6:00 p.m. meeting
Section on Dermatology-Syphilology
RUDOLPH L. BAER, M.D.
New York, New York
DONALD J. BIRMINGHAM, M.D.
Cincinnati, Ohio

5:00 p.m. meeting-dinner
Section on Otolaryngology and Detroit Otolaryngology Society
JOHN J. CONLEY, M.D.
New York, New York

5:00-6:00 p.m. meeting
Section on Ophthalmology
ROBERT W. HOLLENHORST, M.D.
Rochester, Minnesota

5:00 p.m. meeting-reception
Section on Urology and Detroit Branch, American Urology Society
HARRY M. SPENCE, M.D.
Dallas, Texas

Friday
September 30, 1960

9:00-9:30 a.m.
ANDREW P. BIDDLE, M.D., LECTURE
PAUL DUDLEY WHITE, M.D.
Boston, Massachusetts

9:30-10:00 a.m.
Gastroenterology-Proctology
E. CLINTON TEXTER, JR., M.D.
Chicago, Illinois

10:00-11:00 a.m.
INTERMISSION TO VIEW EXHIBITS

11:00 a.m.-12:00 M.
General Practice and Nervous and Mental Disease Panel
JOHN W. RICE, M.D.
Jackson, Michigan
C. KNIGHT ALDRICH, M.D.
Chicago, Illinois
LEONARD L. LOVSHIN, M.D.
Cleveland, Ohio

12:00-12:30 p.m.
Pathology
R. DOROTHY SUNDBERG, M.D.
Minneapolis, Minnesota

12:30 p.m. luncheon-meeting
Section on Pathology and Michigan Pathological Society
R. DOROTHY SUNDBERG, M.D.
Minneapolis, Minnesota

1:00-2:00 p.m. luncheon-meeting
Section on Gastroenterology-Proctology
E. CLINTON TEXTER, JR., M.D.
Chicago, Illinois

END OF 1960 ANNUAL SESSION

Technical Exhibitors

(Alphabetic List)

Abbott Laboratories **Booth No. 16**
North Chicago, Ill.

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

A. S. Aloe Company **Booth No. 73**
St. Louis, Mo.

Practical displays of Swedish stainless instruments will be featured as well as examining equipment and diagnostic aids to office practice. Tom and Wallie Boufford and Wilson Whiteside will be on hand to greet our visitors.

Ames Company, Inc. **Booth No. 26**
Elkhart, Ind.

Ames Company's exhibit will feature COMBISTIX, new "dip-and-read" reagent strips which are a colorimetric combination test for urinary protein, glucose and pH. One dip gives three results in ten seconds.
Available for demonstration will be the other Ames diagnostics for quick reliable and economical urinalyses.
You are cordially invited to discuss these products with our representatives.

Armour Pharmaceutical Company **Booth No. 95**
Kankakee, Ill.

The Armour Pharmaceutical Cmpany exhibit will feature Chymoral, a new systemic anti-inflammatory enzyme tablet which reduces inflammation, swelling and pain. Also included will be Pentritol tempules which release 30 mg. of pentaerythritol tetranitrate in three divided doses to provide twelve-hour relief in angina pectoris and Chymar Aqueous, the parenteral systemic anti-inflammatory enzyme, and Chymar Ointment, the topical form.

Baker Laboratories, Inc. **Booth No. 59**
Cleveland, Ohio

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.
Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Barry Laboratories **Booth No. 18**
Detroit, Mich.

Sterile Injectables
Allergy Products
Merphene
MERPHENE, the perfect germicide that will not damage mucous membranes but will KILL antibiotic resistant staphylococcus aureus in less than fifteen seconds, and tetanus spores in less than five minutes. Ask our representative to show you the confirmed reports.
BARRY ALLERGENS, the newest in antigens testing and treatment.

Belle Moss Mfg. Chemist **Booth No. 56**
Detroit, Mich.

DIAPREX OINTMENT, for effective treatment and prevention of Diaper Rash. It is also useful for adults as well as for children in Heat Rash, Chafing and other skin irritations.
CARBAX EMOLLIENT, a new bland water soluble antipruritic for all types of eczemas and skin irritations overtreated with antibiotics, tars and other medicaments.

Borcherdt Company **Booth No. 54**
Chicago, Ill.

Borcherdt's are featuring:
MALT SOUP EXTRACT: Laxative food supplement for infants, children and adults, and for dietary treatment of pruritus ani.
UROLITIA: Relieves painful urination and clears infected urine in chronic urinary infections, without toxicity or drug fastness.
FERROMALT: Ferrous sulfate, combined with Malt Soup Extract, for treatment of iron deficiency anemia. No constipation, no diarrhea, no gastric irritation.
Stop in for recently published papers.

The Borden Company **Booth No. 27**
New York, N. Y.

Featuring Bordens new pediatric creme METHAKOTE for the treatment of diaper rash in all degrees of severity. Eliminates B ammonigenes the causative factor and prevents staph and other secondary invaders. The added sulphur-bearing amino acids accelerate wound healing at site of lesion. Complete information on METHAKOTE and our infant formulas, Bremil and Mull-Soy, is available at Booth No. 27 through our courteous representatives.

Burroughs Wellcome & Company **Booth No. 93**
Tuckahoe, N. Y.

Burton, Parsons & Company **Booth No. 78**
Washington, D. C.

You are cordially invited to visit the Burton, Parsons & Company booth where information, samples and literature will be available for our EKG Sol, the modern electrode cream for electrocardiography and electroencephalography, along with our original bulk preparations, Konsyl and L. A. Formula. L. A. Formula contains 50% bulk producing material dispersed in an equal amount of lactose and dextrose. Konsyl, on the other hand, contains 100% bulk producing material and is certainly the product of choice for the obese, the diabetic, and others with restricted caloric diets.

Cambridge Instrument Company, Inc. **Booth No. 45**
New York, N. Y.

CAMBRIDGE INSTRUMENT COMPANY, INC., New York City, Booth No. 45. The Cambridge "Versa-Scribe"—the Versatile Portable Electrocardiograph; and the Cambridge "Simpli-Scribe" Model Direct-Writing Portable Electrocardiograph will be displayed at this booth. Also other important Cambridge instruments, including the Audio-Visual Heart Sound Recorder, Operating Room Cardioscope, Educational Cardioscope, Multi-Channel Physiological Recorder, Electrokymograph, Plethysmograph, pH Meters, and Pulmonary Function Tester.
The Cambridge Engineers in attendance will be glad to give you complete information on these instruments.

Cameron Surgical Specialty Co. **Booth No. 29**
Chicago, Ill.

To help in your diagnostic procedures and office surgery, Cameron shows its new Electro-Surgical Units incorporating the modalities and convenience essential to modern office surgery. The modern, efficient electrosurgical family includes the 255 and the new 265.

Also showing Suction Coagulation Electrodes, Snares, electrically illuminated Ano-Procto-Sigmoidoscope equipment (distal and proximal), Otoscopes, Mouth Gags, Transilluminators, Gastroscopes, et cetera. Cameron's continuing research program results in excellent instrumentation, considerately priced.
We would like the opportunity of demonstrating to you.

Carnation Company **Booth No. 10**
Los Angeles, Calif.
Carnation Company cordially invites you to visit Booth No. 10, where Medical Specialist representatives will be pleased to welcome you.
Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, and our newest product CARNALAC are available.
Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Central Pharmacal Company **Booth No. 70**
Seymour, Ind.
Central's exhibit will feature CENASERT IMPROVED an effective new weapon for treating Trichomonal, monilial and bacterial vaginitis. Medical service members of our staff will be in attendance at our booth to discuss this specialty and others that will be on display.

Chicago Pharmacal Company **Booth No. 63**
Chicago, Ill.
URISED: Clinically proven tablet for both comfortable sedation and thorough antisepsis in genito-urinary affections.
JUNIPLEX: Pleasant tasting liquid tonic containing essential minerals, B complex plus 30 micrograms of Vitamin B_{12} per teaspoonful.
ESTROSED: Tablet containing reserpine and ethinylestradiol for treatment of the menopausal syndrome.
BITAVITA: Delicious, refreshing citrus flavored, chewable vitamin supplement tablet for both children and adults.

Ciba Pharmaceutical Products, Inc. **Booth No. 24**
Summit, N. J.
ISMELIN
Ismelin is a new CIBA antihypertensive indicated in advancing hypertension. Alone, or in combination, it has lowered blood pressure effectively in 80 to 90 per cent of patients.
Ismelin affords a new way to control hypertension: Since it acts at the site of arteriolar blood pressure regulation—that is, the nerve-arteriole junction—Ismelin has no central or parasympathetic effects. CIBA representatives will be glad to discuss this and other CIBA products.

Coca-Cola Company **Booth No. 83**
Atlanta, Ga.
Ice-cold Coca-Cola served through the courtesy and cooperation of the Detroit Coca-Cola Bottling Company and The Coca-Cola Company.

Desitin Chemical Company **Booth No. 7**
Providence, R. I.
DESITIN OINTMENT: For treatment of burns, ulcers, diaper rash, abrasions, etc.
DESITIN POWDER: Relieves chafing, sunburn, diaper rash, etc.
DESITIN SUPPOSITORIES and RECTAL OINTMENT: Relieve pain and itching in uncomplicated hemorrhoids, fissures.
DESITIN BABY LOTION: Protective, antiseptic.
DESITIN ACNE CREAM: A non-staining, flesh-tinted "Medicream" for the treatment of Acne Vulgaris.
DESITIN COSMETIC & NURSERY SOAP: Supermild.
DESITIN SUPPOSITORIES with HYDROCORTISONE: Prompt response to inflammatory conditions in proctitis, severe pruritus, edema.

Dictaphone Corporation **Booth No. 68**
Detroit, Mich.
An exhibit of the latest electronic dictating equipment. Featuring Dictaphone Telecord Remote Central Dictating, Dictet and Dictaphone Interview Recording systems. Telephone Recording for Medical Information. All equipment exhibited as it applies exclusively to the medical profession.

Dietene Company **Booth No. 76**
Minneapolis, Minn.
Have you tasted Meritene? Meritene is the good-tasting *Protein*-vitamin-mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.
While there, review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.

Doho Chemical Corporation **Booth No. 25**
New York, N. Y.
DOHO CHEMICAL CORPORATION is pleased to exhibit:
AURALGAN: Otitis Media and removal of Cerumen.
OTOSMOSAN: Fungicidal and Bactericidal in the suppurative and aural dermatomycotic ears.
RHINALGAN: Nasal decongestant free from systemic or circulatory effect.
LARYLGAN: Throat spray and gargle for infectious and non-infectious sore throat involvements.
Mallon Chemical Corporation, Division of DOHO:
RECTALGAN: For relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.
DERMOPLAST: An Aerosol Spray for surface pain, burns and abrasions; Obs. & Gyn. use.

Eaton Laboratories **Booth No. 53**
Norwich, New York
Furacin® (brand of nitrofurazone) Cream aids cervical and vaginal tissue toward a rapid return to a healthy, normal state in the postpartum period; safely controls cervicovaginal infection in the puerperium, prevents chronicity; averts infection and delayed healing of cervix and episiotomy wound; reduces discharge, irritation and maloder; increases postpartum comfort.

Emanem Laboratories, Inc. **Booth No. 30**
Chicago, Ill.
DUTEX is a retention douche. The retention principle is an entirely new concept. DUTEX gradually distends the vaginal folds and exposes the entire vaginal vault to the solution. DUTEX is an important new treatment for trichomonas vaginitis, moniliasis and nonspecific vaginitis.

Encyclopaedia Britannica, Inc. **Booth No. 41**
Detroit, Mich.
ENCYCLOPAEDIA BRITANNICA AGAIN HAS BEEN ACCLAIMED THE STANDARD OF THE WORLD IN THE ENCYCLOPAEDIA FIELD. OUR LATEST EDITION WILL BE ON DISPLAY. REPRESENTATIVES ON DUTY: T. ELLIOTT AND P. JOHNSON.

Ferndale Surgical, Inc., Division
J. F. Hartz Company **Booth No. 65**
Ferndale, Mich.

Geigy Chemical Corporation **Booth No. 60**
Yonkers, N. Y.

Geigy Pharmaceuticals cordially invites Members and Guests of the Association to visit its technical display. Its original contributions to modern therapy of cardiovascular, rheumatic, psychiatric and metabolic disorders will be presented by representatives in attendance.

Gerber Products Company **Booth No. 34**
Fremont, Mich.

NEW! Gerber MODILAC . . . A complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Gray Manufacturing Company **Booth No. 8**
Hartford, Conn.

Hack Shoe Company **Booth No. 2**
Detroit, Mich.

We can and will display shoes designed with your prescription in mind but we can't show the type of careful fitting, the ethical considerations, the feeling for the niceties of the patient-doctor relationship which have made the HACK SHOE COMPANY the choice of Doctors of Medicine over the past forty-four years . . . whenever a patient requires proper shoes, correctly fitted.

G. F. Harvey Company, Inc. **Booth No. 82**
New York, N. Y.

The G. F. Harvey exhibit features Paremycin Elixir and Fungacetin preparations.

Paremycin Elixir, "the duoclassic antidiarrheal," provides an exclusive combination of tincture of opium and neomycin sulfate in a non-chalky, deliciously banana-flavored elixir.

Fungacetin Ointment, Liquid, and Powder afford unique topical antifungal actions through a self-regulating and completely non-irritating chemoenzymatic mechanism.

Health Insurance Council **Booth No. 77**
New York, N. Y.

Our exhibit is designed to provide general information on health insurance as underwritten by insurance companies. In addition, it also makes available information on uniform claim forms for use by doctors and hospitals in support of health insurance claims.

H. J. Heinz Company **Booth No. 20**
Pittsburgh, Pa.

HEINZ BABY FOODS announces these new varieties: Pineapple Juice with vitamin C added; five attractively packaged and newly formulated pre-cooked cereals; High Meat Dinners—Chicken a la King and Chicken with Rice. Convenient SCREW-ON caps are on most Heinz Baby Foods now.

New literature—A B C's for Baby's Mealtime—revised baby food lists.

Holland-Rantos Company, Inc. **Booth No. 21**
New York, N. Y.

The H-R exhibit will feature:

. . . Antimycotic (non-messy) *HYVA Gentian Violet Vaginal Tablets;*

. . . *NYLMERATE Jelly and Antiseptic Solution Concentrate* for vaginal trichomoniasis and mixed infections;

. . . *HOLLANDEX Silicone Ointment with Natural Vitamins A & D*—for neuro- and contact-dermatitis, decubitus ulcers, diaper rash, minor superficial skin disorders;

. . . *Special KOROMEX A*—for use when "jelly-alone" is indicated for conception control;

. . . *Contouring KORO-FLEX Diaphragms* (facilitate correct placement); standard *KOROMEX Jelly, Cream, Diaphragms and Sets.*

G. A. Ingram Company **Booth Nos. 85-86**
Detroit, Mich.

Johnson & Johnson **Booth No. 35**
New Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Several recent outstanding additions to the Baby Products line will be shown. Other products, designed for your office, hospital, or patient use, will be displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

A. Kuhlman & Company **Booth No. 37**
Detroit, Mich.

The A. Kuhlman Company will feature the Ambu Emergency Rescue Breathing Kit—a resuscitator that can be used with oxygen or air plus a portable suction pump. Not a second is lost on assembly or connections to electricity or compressed gases. Lightweight, compact, rugged, always ready for action, the Ambu is so simple almost anyone can use it to save a life.

Lederle Laboratories **Booth No. 90**
Pearl River, N. Y.

You are cordially invited to visit the Lederle booth where our medical representatives will be in attendance to provide the latest information and literature available on our line.

Featured will be DECLOMYCIN® Demethylchlortetracycline, the most recent contribution to broad-spectrum antibiotic therapy, ARISTOCORT® Triamcinolone, the highly effective, well tolerated corticosteroid, and other products of Lederle research.

Eli Lilly & Company **Booth No. 92**
Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in Booth No. 92. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth No. 32**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. Lorillard Company **Booth No. 66**
New York, N. Y.

P. Lorillard Company invites you to visit the KENT Cigarette exhibit.

We are presenting the Story of KENT Cigarettes. You will learn why KENT satisfies your appetite for a real good smoke, every time.

KENT uses only the finest natural tobaccos for true tobacco taste. And KENT's famous Micronite filter has a free and easy draw so KENT's good tobacco taste comes right through to you.

A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the convention.

Maico Hearing Service **Booth No. 87**
Detroit, Mich.

The new Maico Hearing Aid weighing less than one-half ounce is so small that the entire unit consisting of transmitter, microphone, receiver, battery and ear mold is worn in the ear. A complete line of instruments to take care of cases from the borderline to the profoundly deaf.

Ninety per cent of all precision hearing test instruments used in America by ear physicians are Maico.

Maltbie Laboratories Division
Wallace & Tiernan, Inc. **Booth No. 22**
Belleville, N. J.

Maltbie Laboratories announces an entirely new chemical entity, DORNWAL, for treatment of anxiety and tension without causing drowsiness. Also featured are: CALDECORT, antifungal antibacterial, anti-inflammatory dermatologic ointment; DESENEX, for athlete's foot; NESACAINE, a safe, potent and rapid-acting local anesthetic; CHOLANS, for hepato-biliary dysfunction; and CALDESENE MEDICATED POWDER for diaper rash.

Marion Laboratories, Inc. **Booth No. 43**
Kansas City, Mo.

One DUOTRATE Plateau CAPsule morning and evening resulted in a dosage decrease of 878 nitroglycerin tablets per week for a group of fifty anginal patients.

Information relating to the various potencies and combinations of DUOTRATE Plateau CAPS, as well as a complete reprint of the above study are available at the Marion booth.

Marshall Erdman & Associates, Inc. **Booth No. 6**
Madison, Wis.

ERDMAN MEDICAL BUILDINGS

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 300 doctors are now practicing in Erdman-built Medical Buildings. Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office.

Contact Marshall Erdman & Associates, Inc., Madison, Wisconsin, before you build.

S. E. Massengill Company **Booth No. 49**
Bristol, Tenn.

Best wishes from Massengill to the Michigan State Medical Society for a most successful meeting. Should you desire, Massengill service representatives will be on hand at the Massengill booth to discuss with you any Massengill product in which you are interested. The S. E. Massengill Company and its service representatives would like to cooperate, in any way possible, to make your meeting a complete success.

McNeill Laboratories, Inc. **Booth No. 79**
Philadelphia, Pa.

Members of the Michigan State Medical Society are cordially invited to visit our Booth No. 79, Mr. W. J. Warzybok in charge. Products to be featured are: GRIFULVIN, Butisol Sodium and Parafon.

Mead Johnson & Company **Booth No. 89**
Evansville, Ind.

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Company **Booth No. 11**
Tulsa, Okla.

Presenting the MEDCO-SONLATOR. Providing a new concept in therapy by combining muscle stimulation and ultra sound simultaneously through a SINGLE Three-Way Sound Applicator.

The MEDCO-SONLATOR is a distinct advance in the effectiveness of physical therapy in your office or hospital. A few minutes spent in our booth should prove of value to your practice.

Medical Arts Supply Company **Booth No. 80**
Grand Rapids, Mich.

Medical Arts Supply Company will show specialized Medical equipment manufactured by Air-Shields, Inc., namely the Ambu-Resuscitator and Foot Pump. Also the new dia-pump compressor aspirator; Ritter equipment, Universal table, Castle type eight lamp, and Liebel-Flarsheim medical equipment.

Medical Protective Company **Booth No. 94**
Fort Wayne, Ind.

As the "No. 1 Malpractice Insurer" (*Medical Economics*, February 3, 1958), The Medical Protective Company offers unexcelled coverage. With exceptional proficiency in defense, so essential to the Doctor's protection today, its experience in successfully handling 80,000 claims and suits during sixty-one years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme **Booth No. 28**
Philadelphia, Pa.

'DIURIL' and 'HydroDIURIL', orally effective, nonmercurial diuretic-antihypertensive agents are featured at the Merck Sharp & Dohme booth. More clinical evidence exists for these potent agents than for all other diuretic-antihypertensives combined.

Technically trained personnel will be present to discuss these and other subjects of clinical interest.

Wm. S. Merrell Company **Booth No. 23**
Cincinnati, Ohio

MER/29, a dramatic new inhibitor of cholesterol biosynthesis will be featured. With MER/29 it is possible to reduce both serum and tissue cholesterol levels with one small capsule daily. Clinical results suggest important medical implications of interest to every practicing physician. Merrell representatives will be pleased to discuss with you the exciting facts about MER/29.

Merrill Lynch, Pierce, Fenner & Smith **Booth No. 47**
Grand Rapids. Mich.

Merrill Lynch's exhibit consists of an eight foot high panel depicting the various services available without charge or obligation to the general public. These include three write-ups on hundreds of securities and educational lectures, courses, and movies about the brokerage business. A counter in front will be provided with many booklets on the brokerage business.

Michigan Bell Telephone Company **Booth No. 67**
Detroit, Mich.

Michigan Bell will demonstrate the latest in efficient, compact telephone equipment and services for the modern office. Included will be the "Call Director" telephone and the new Dialaphone—which automatically dials up to 850 numbers at the push of a button.

Also featured will be the new "Princess" phone with the built-in night light.

Michigan Medical Service **Booth No. 3**
Detroit, Mich.

You are cordially invited to visit our booth to obtain current information regarding Michigan Medical Service (Blue Shield). Our representatives will gladly visit

with you and answer any questions you may have with regard to your Blue Shield Plan.

Milex Products **Booth No. 42**
Oak Park, Mich.

Milex Company is pleased to announce the release of a new Guide for Teen-Agers and a new product in Infertility. Also on exhibit will be other unique specialties as: Milex Folding, Cube and Inflatable Pessaries, Trimo-San Gel for vaginal fungal infections, Amino-Cerv Gel a postoperative and cervicitis treatment gel—Marital and Menopause Guides and cancer detection unit.

MSMS Life, Health and Accident Insurance Program **Booth No. 39**
Lansing, Mich.

You are cordially invited to stop at Booth No. 39 and discuss the MSMS Life, Health and Accident Insurance Program.

Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

Wm. R. Niedelson Company **Booth No. 75**
Detroit, Mich.

For those interested in accuracy in basal metabolic studies, and pulmonary function tests, the Jones "AIR BASAL" will be demonstrated.

If you have a problem in x-ray, visit our booth and discuss it with our technical staff.

PROFEXRAY literature and specifications will be available, as well as the newest in x-ray accessories.

Hermien Nusbaum & Associates **Booth No. 14**
Chicago, Ill.

You are cordially invited to visit our booth and examine the following items of interest to physicians for their own families as well as for patient and institutional use:

EVENFLO infant feeding line consisting of glass and boilable plastic bottles; preemie and other types of nipples and feeding equipment. FOUNTAIN SPOON: no muss or fuss dipping into food and removing excess. INFANSEAT: Feeding chair; safe car-seat: baby carrier from birth to one year. CUDDLESEAT—Convenient carrier for toddler.

Ortho Pharmaceutical Corporation **Booth No. 40**
Raritan, N. J.

At Booth No. 40 ORTHO is introducing a new monilicidal vaginal cream, SPOROSTACIN Chlordantoin Cream. This emollient white cream contains the unique chemical, chlordantoin, which, because of its structure, has the unusual ability to penetrate the monilial membrane. Clinically proved, SPOROSTACIN Cream is the treatment of choice in monilial vaginitis.

Parke, Davis & Company **Booth Nos. 50-51**
Detroit, Mich.

Medical Service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Pet Milk Company **Booth No. 91**
St. Louis, Mo.

We shall be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets.

Pfizer Laboratories **Booth No. 15**
Brooklyn, N. Y.

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Procter & Gamble Company **Booth No. 31**
Cincinnati, Ohio



Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians.

Mrs. Christyne Schwab in charge.

Professional Management **Booth No. 84**
Battle Creek, Mich.

Professional Management—

A complete Business Service for the Medical Profession. The trade mark PM is a brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

Those in attendance at the MSMS Convention are cordially invited to stop at Booth No. 84 and meet the experienced PM Executives there.

Purdue Frederick Company **Booth No. 62**
New York, N. Y.

The Purdue Frederick Company will present:

Athrombin-K: The first potassium salt of Warfarin. Retains all clinical advantages of Warfarin therapy. 25 per cent less costly.

Senokot: Constipation corrective. Concentrated total senna glycosides which activate Auerbach's plexus, initiate normal neuroperistalsis.

Arthropan: New rapidly absorbed choline salicylate, producing anti-inflammatory, analgesic, antipyretic effects in short time without gastric irritation.

Pharycidin: The first triple-action throat medication. Provides medical and systemic analgesia plus antibacterial action through gargling and swallowing.

Cerumenex: Cerumenolytic for the quick removal of excessive cerumen. Contains Cerapon, a new surfactant, with propylene glycol and chlorbutanol.

Randolph Surgical Supply Company **Booth No. 13**
Detroit, Mich.

Randolph Surgical will display many new products, one which has created great interest, The Bird Residual Breather for Pulmonary disorders.

R. J. Reynolds Tobacco Company **Booth No. 52**
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM, or CAVALIER King Size Cigarettes.

A. H. Robins Company, Inc. **Booth No. 17**
Richmond, Va.

Robins exhibit is featuring the *Dimetane Expectorant* formulations for control of allergy-associated coughs; *Phenaphen* and *Phenaphen* with *Codeine,* which provide the synergistic benefits of analgesia and sedation; *Robaxin,* specific for skeletal muscle relaxation; *Robaxisal,* new formulation combining the relaxant action of Robaxin with the pain relieving action of aspirin; and *Pabalate* (plain, sodium-free or with hydrocortisone), indicated in rheumatoid arthritis and its variants.

Roche Laboratories **Booth No. 74**
Nutley, N. J.

LIBRIUM—a new, unique and versatile therapeutic agent which is virtually specific for the relief of irrational fear, anxiety and tension.

MADRIBON—is a completely new, low-dosage sulfonamide of particular value in the treatment of bacterial infections, especially respiratory infections.

TIGAN—a new, specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

J. B. Roerig & Company **Booth No. 71**
New York, N. Y.

The Roerig Booth No. 71 will feature a new product, MAXIPEN, The Orally Maximal Penicillin. MAXIPEN provides substantially higher blood levels than older oral forms, maximal absorption, maximal flexibility, and maximal oral indications.

Wm. H. Rorer, Inc. **Booth No. 48**
Philadelphia, Pa.

Features: MAALOX, the non-constipating, pleasant tasting antacid, and the new MAALOX NO. 2 (double strength) TABLET. Other product highlights are ASCRIPTIN, a rapid-acting professional salicylate, FERMALOX, a buffered iron preparation, and PAREPECTOLIN, a pleasant tasting antidiarrheal preparation for patients of all ages. Representatives will be on hand to answer questions about these and other Rorer products.

Ross Laboratories **Booth No. 46**
Columbus, Ohio

Ross Laboratories, who also manufactures Similac, features SIMILAC WITH IRON, a new prepared infant formula supplying 12 mg of ferrous iron per quart of formula. SIMILAC WITH IRON is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

Rupp & Bowman Company **Booth No. 88**
Highland Park, Mich.

Welcome again, members of the Michigan State Medical Society. Please stop in and visit with our representative.

W. B. Saunders Company **Booth No. 1**
Philadelphia, Penna.

Bridegroom Rozema will be on hand with the complete Saunders line. A few of the newer clinical titles include: Greenhill Obstetrics; Frederick and Towner: The Office Assistant; Mulholland et al: Surgical Management; Schaffer: Diseases of the Newborn; Leavell & Thorup: Clinical Hematology; Bakwin & Bakwin: Behavior Disorders in Children; and Williamson: Office Diagnosis.

Schering Corporation **Booth No. 19**
Bloomfield, N. J.

The members of the Michigan State Medical Society are cordially invited to visit the Schering booth. Products featured will be Fulvicin, the first oral antifungal antibiotic for ringworm; Alpen, new synthesized oral penicillin; Naqua, effective new oral diuretic—and antihypertensive; and Diloderm, first chlorinated steroid with specific topical effectiveness.

Julius Schmid, Inc. **Booth No. 12**
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm; RAMSES Flexible Cushioned and BENDEX Disphragms; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and ESQUIRE Rubber Condoms for the control of trichomonal re-infection.

G. D. Searle & Company **Booth No. 58**
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be our new Aldosterone-Blocking Agent for edema or ascites, Aldactone.

Smith, Kline & French Labs. **Booth No. 69**
Philadelphia, Pa.

Our representatives cordially invite you to discuss with them: (1) 'Ornade' Spansule® capsules, the unique oral nasal decongestant for treating symptoms of hay fever and other allergies; (2) Eskatrol® Spansule® capsules, for daylong control of appetite and relief of the emotional stress that causes over-eating in "problem" overweight patients; (3) Fortespan® capsules, high potency multivitamins—therapeutic formula—in Spansule® sustained release capsules; and (4) 'Prinadol', a potent narcotic agent for the relief of pain.

Smith, Miller & Patch, Inc. **Booth No. 5**
New Brunswick, N. J.

SMITH, MILLER & PATCH, Inc. N. Y., N. Y. features: VITRON-C . . . a new oral hematinic, clinically proven effective in treating iron deficiency anemia in patients with iron intolerance, gastrointestinal irritability or ulcerative disease. VITRON-C offers high therapeutic levels of iron with maximum toleration.

BISTRIMATE—First choice in the treatment of "Chronic Sore Throat". Recent reports on a group of patients indicate 89.1 per cent complete or partial relief. In certain dermatoses of suspected viral origin, no serious toxicity to BISTRIMATE has been noted in over thirteen years' use.

Company representatives will welcome the opportunity to discuss other specialties; LIPOTRIAD—a nutritional supportive proven of value in the treatment of degenerative retinopathies and KONDREMUL, the micromulsive bowel regulator.

E. R. Squibb & Sons **Booth No. 36**
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At Booth No. 36, we are pleased to present up-to-date information on these advances for your consideration.

The Stuart Company **Booth No. 38**
Pasadena, Calif.

The Stuart representatives extend a cordial invitation to physicians attending this meeting to visit their booth and discuss with them the latest developments of The Stuart Company. The products to be featured are MYLICON—a new product for gastric distress, and VITA-DRINK—a new pleasant-tasting multivitamin dosage form.

Testagar & Company **Booth No. 61**
Detroit, Mich.

The professional service representatives of Testagar & Co., Inc., will be happy to pass on the latest information on the use of Heparin Sodium (Hepathrom) as an office procedure in the treatment of acute and chronic atherosclerotic conditions; as a treatment for peripheral artery diseases. Information is also available on the use of Heparin (Hepathrom) as a prophylactic in coronary artery diseases. Information, samples and literature will also be available on Felsules (Chloral Hydrate—Fellows). The latest literature stresses the value of Chloral Hydrate in the geriatric patient.

S. J. Tutag & Company **Booth No. 44**
Detroit, Mich.

S. J. Tutag & Company introduces a new antiobesity agent for prompt and emphatic hunger control . . . with little or no central nervous system stimulation.

Cydril is a new chemical componnd that possesses anorectic action with low toxicity. *Cydril* is available in two forms, tablet and the sustained-release Tutag Granucap.*

Adults and children over twelve years, one *Cydril* tablet three times daily, preferably one-half hour before meals, or one *Cydril* Granucap* in the morning, or as directed.

*Granucap—T.M. Reg. U.S. Pat. Off.

The Upjohn Company **Booth No. 57**
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

U. S. Vitamin Corporation **Booth No. 64**
New York, N. Y.

On display—ARLIDIN—a specific safe vasodilating, vasorelaxant drug which effectively increases blood flow to the brain, inner ear, and eye. In arteriosclerosis obliterans, diabetic vascular disease, thromboangiitis obliterans and ischemic ulceration, ARLIDIN increases walking ability; promotes healing of ulcers; alleviates pain, ache, spasm and numbness.

Wallace Laboratories **Booth No. 9**
New Brunswick, N. J.

The representatives of Wallace Laboratories will look forward to discussing the drug, DEPROL, for the treatment of depression at Booth No. 9. DEPROL consists of MILTOWN plus benactyzine, a specific and effective formula for treating acute and chronic depressions. The drug is safe, side effects are few and easily controlled and it has been clinically proven in thousands of patients.

Warner-Chilcott Laboratories **Booth No. 81**
Morris Plains, N. J.

Nardil—Safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality with no toxic effect on blood, liver or kidneys.

Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Clinically superior because it is nonconstipating. Ideally suited for the peptic ulcer patient because it contains no laxative which might cause irritation and hypermotility.

Westwood Pharmaceuticals **Booth No. 55**
Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream—Fostex Cake—Sebulex—Lowila Cake—Lowila Emollient—Alpha-Keri.

These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories **Booth No. 33**
Kenilworth, N. J.

White Laboratories' exhibit features SORBOQUEL—the result of a decade of laboratory experimentation and over five years of clinical confirmation.

SORBOQUEL, a totally new agent for truly effective control of both chronic and acute diarrhea, has been demonstrated effective in 85 per cent of chronic and 94 per cent of acute cases of diarrhea.

Winthrop Laboratories, Inc. **Booth No. 72**
New York, N. Y.

pHisoAc, a new therapeutic topical cream for acne and related skin blemishes, contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent, in a fat-free, quick drying flesh toned base. It is virtually odorless, spreads smoothly and evenly and can readily be washed off with water. pHisoAc Cream is keratolytic also removes excess oil and helps dry and degerm the skin, unblock clogged pores, and remove blackheads.

Convention Sidelights

When the political spotlight was on Chicago for the Republican National Convention, a physician had a unique honor. Walter H. Judd, M.D., Minnesota Congressman, was the keynote speaker, becoming the first physician to serve in this capacity.

Edward R. Annis, M.D., of Miami, representing the American Medical Association, triggered a verbal battle before the Platform Committee of the Democratic Party at its July 5 session when he charged that National Chairman Paul Butler already has stated that the 1960 platform will endorse a bill to tie health care benefits for the aged to the social security system. This, Doctor Annis said, would be socialism. "Your mind has been made up for you," Doctor Annis asserted. "Don't force doctors to fight within the party or force us to leave the party."

ANNUAL REPORT OF THE COUNCIL

1959-1960

The Council met as a whole every month during the past year, holding eleven meetings covering thirteen days (prior to September 26, the date of the 1960 Annual Session convened); over 900 items were considered by the full Council.

Membership

Membership as of June 30, and as of December 31, from 1935 to 1960 is indicated in the following chart:

	1935	1945	1955	1957	1958	1959	1960
June 30	3,410	4,425	5,503	6,104	6,175	6,461	6,660
December 31	3,543	4,686	6,109	6,504	6,638	6,652	

The Scientific Side

The Michigan State Medical Society has as its prime purposes "to encourage among members of the medical profession the interchange of views on all phases of professional advancement, and thus better to equip each member of the profession to serve society and to promote the health of the people"; . . . "to maintain a program of scientific education for the members of the society keyed to the constantly developing discoveries in the field of medicine; and to foster, encourage, and coordinate postgraduate facilities for the medical profession as a whole."

The scientific achievements of the Society continue to be its greatest service to the public and its most valuable benefit to its members. During the past year, they included:

(a) The high quality program of the MSMS Annual Session which in September, 1959 was held in Grand Rapids and attracted a registration of 3,115, including 1,516 M.D.'s.

(b) The Michigan Clinical Institute, the refresher course which received great praise for its superb scientific program last March. Attendance reached 2,975, including 1,511 M.D.'s. The contribution of Smith, Kline & French Laboratories with its closed circuit color television program, and the American Cyanamid Company which sponsored colored movies on surgery, added immeasurably to the success of this educational meeting.

(c) The extra-mural postgraduate courses sponsored by MSMS, the University of Michigan Medical School and Wayne State University College of Medicine aided in maintaining the Society's high scientific standing.

(d) Following through on another Purpose of the Society: "To disseminate advances in medical research among the profession generally by the issuance of scientific publications," THE JOURNAL of the Michigan State Medical Society continues to hold its position as a leader among State Medical Journals. THE JOURNAL MSMS is truly an outstanding scientific publication, of which all members may well be proud.

(e) The State Society must continue to commend its fifty-five component societies for their quality scientific programs, including those held at regular meetings, at special clinics, and on scientific "days."

Finance

Every thirty days the Society's financial picture is reviewed by The Council, and periodically the Finance Committee meets to advise The Council on particular fiscal matters. The Auditor's report for 1959 plus the budgets of the Society for 1960, were published in JMSMS, March 1960, beginning on page 469. Members are invited to review the financial status of their State Medical Society and suggestions for improvement are always appreciated.

The income from membership dues is allocated to the various activities of the Michigan State Medical Society as instructed by the Finance Committee and The Council in January. Through June 30, 1960 the total income of the Society from all sources has been $589,265.69 and expenses, including $93,677.74 in addition to the new headquarters building, have totaled $364,320.05. A brief financial résumé of each of the MSMS activities, as of June 30, 1960, is presented in the accompanying table:

Account	On Hand 12/1/59	Income to 7/1/60	Expenses to 7/1/60	Balance on Hand 7/1/60
General Fund	$152,033.93	$159,194.38	$122,335.33	$188,892.98
Annual Session	.....	26,216.21	4,278.74	▽ 21,937.47
Michigan Clinical Institute	.....	14,215.00	13,655.51	559.49
THE JOURNAL	.....	85,286.79	73,625.95	11,660.84
Public Education	19,651.34	52,817.30	23,238.09	49,230.55
Public Service	8,683.54cr.	25,657.59	8,147.13	8,826.92
Professional Relations	9,134.49cr.	35,617.00	20,863.48	5,619.03
Public Education Reserve	50,000.00	.....	.....	50,000.00
Rheumatic Fever Control	3,275.12	2,180.67	2,435.82	3,019.97
Contingent Fund	.....	8,515.49	.....	8,515.49
Building Fund	4,936.60	.....	2,062.26	2,874.34
MSMS Headquarters Fund	125,188.04	85,887.52	93,677.74	117,397.82
New Headquarters Under Construction (Equity)	159,334.14	93,677.74	.....	253,011.88
TOTALS	$496,601.14	$589,265.69	$364,320.05	$721,546.78

For the first seven months of the current fiscal year since December 1, 1959, 5630.5 members have paid AMA dues of $140,762.50. This amounts to 98.1 per cent of the dues paying members of the Society. An up-to-date résumé of the financial status of the Society will be presented to the House of Delegates in September as a part of the Supplemental Report of The Council.

The Journal

In its fifty-eight years' history, THE JOURNAL of the Michigan State Medical Society has published a Number every month: the 700th issue will appear in December, 1960! The JOURNAL attempts to keep the membership informed on the progress of the State Society in scientific advance and in economic and political aspects as they affect the practice of medicine and the individual doctor.

The Publication Committee, as for some ten years, continued to assign each number of THE JOURNAL to a particular subject which during the past Society year covered heart and rheumatic fever, rural health, a number dedicated to the memory of Secretary L. Fernald Foster, M.D., cancer control, geriatrics, Michigan Medical Service, the MSMS Annual Session, a feature on the Kalamazoo Academy of Medicine, mental health, diabetes

detection, and the Michigan Clinical Institute. Also, published were three supplements: one containing Proceedings of the House of Delegates Session; another listing all committee personnel; and the third containing the directory of members of MSMS, of its Woman's Auxiliary, and of the Michigan State Medical Assistants Society; this supplement also reprinted the MSMS Constitution and Bylaws. The next Roster supplement will include an alphabetical index, for the greater convenience of our members who frequently must refer to this list.

Prior to publication, all editorials, written by the Editor, were scanned by the Editorial Board (Publication Committee) which is in charge of editorial policy. The editorials largely have been of a socio-economic nature in order to present to the membership the policy and program of the Society as established by the House of Delegates.

JMSMS was signally honored by the State Medical Journal Advertising Bureau Conference when it received top award for the excellence of its cover design.

Beginning January, 1960, THE JOURNAL adopted an entirely new "face"; its typography was improved and the layout of the entire book was modernized in order to make the publication not only more attractive in appearance but more easily read by members. Favorable comments from physicians indicate that these efforts met with general approval.

Your Editor is grateful for the help and fine suggestions he has received from MSMS Delegates, Officers, Councilors, and from many members, as well as from the executive staff, during the past year. While the Society can be proud of THE JOURNAL, the Editor's constant quest is to make it a better vehicle so that its goal, to disseminate advances in medical research among the profession generally, is more adequately and successfully achieved.

Organization

1. The President's Program of MSMS, inaugurated November 18 and approved by The Council, was unveiled at the County Secretaries-Public Relations Seminar on January 30, 1960. This is a five-year program to culminate with the centennial celebration of the Society in 1965 (a detailed report is being presented to the House of Delegates by President Darling).

A recommendation on this subject follows.

2. During the past Society year, The Council held monthly meetings, permitting all of its twenty-five members the opportunity to deliberate and decide on the numerous and grave problems which faced the Society.

3. Communication between the Councilors and Delegates was improved during the last year as the result of specific recommendations offered by Council Chairman H. J. Meier, M.D. and approved by The Council. These included suggestions to each Councilor that he add notes of explanation and interest when sending to Delegates copies of Council minutes; that the Councilors make periodic (quarterly) requests in writing to Delegates that they report on local problems and recommendations; that Councilors discuss verbally, or in writing, subjects and programs inaugurated by the State Society that might be controversial so that the Delegates have proper background; that component societies record with the MSMS Secretary such policy-making decisions, public relations activities, or any items of information the county society believes the rest of the component societies would benefit by, and thus contribute to the State Society.

The Councilor Conferences were continued as in the past, to gain advice of Delegates, Alternate Delegates, and component society officers, in advance of the House of Delegates Session on important matters on the agenda of that body.

A recommendation on this subject follows.

4. Mrs. W. G. Mackersie of Detroit was installed as President of the Woman's Auxiliary to the American Medical Association in Miami Beach last June. Full recognition is due this Michigan lady, the first from our State to receive this great honor.

A recommendation on this subject follows.

5. The Awards Dinner was held in Detroit on January 30 to recognize national medical and health leaders and organizations of Michigan which contributed outstanding service to better health of the citizens of this State. The awardees were:

Reed M. Nesbit, M.D., Ann Arbor, President, American Association of Genito-Urinary Surgeons; H. Marvin Pollard, M.D., Ann Arbor, President, American Gastroenterological Association; and Milton L. Sorock, M.D., Detroit, President, Johnston Surgical Society.

Miss Ella K. Longley, Ludington, Superintendent Paulina Stearns Hospital for conducting "This is Your Hospital," a weekly radio program, for six years; *Muskegon Chronicle* for reporting on polio immunization in general; and C. S. Mott, Flint, President of Mott Foundation, for many and valuable contributions to the health of his fellow men through philanthropy and personal dedication.

The following radio stations, for programming special public service broadcasts on health subjects: WAGN, Menominee; WBCK, Battle Creek; WBRN, Big Rapids; WDET, Detroit; WELL, Battle Creek; WLDM, Detroit; WMDN, Midland; WOAP, Owosso; and WWBC, Bay City.

6. The County Secretaries-Public Relations Seminar, held in Detroit on January 30-31, 1960, gave the State Society opportunity to impart valuable information on socio-economic matters to the elected leaders of MSMS and of the component societies. This is, indeed, a splendid leadership-training meeting.

7. The Residents-Interns-Senior Medical Students Conference again was featured during the Michigan Clinical Institute on March 10, 1960. This is the main contact of MSMS with the future doctors of the State.

8. The MSMS Workshop on Aging, held at Kellogg Center, East Lansing, on April 3, must be included in this section under Organization. The implementation of the following ten recommendations adopted at this Workshop is heartily endorsed by The Council as a prime necessary objective of the Society. The House of Delegates members and all the medical profession of Michigan are urged to enter vigorously into the work of achieving these objectives:

(a) Removal of compulsory retirement by industry and labor through voluntary and legislative action.

(b) Encourage and work for program to provide work opportunities for the aged.

(c) Encouragement of state and community governments to share the purchase cost of voluntary health insurance for those over 65 who need financial assistance.

(d) Participation by the medical profession in the preliminary meetings on local and state levels prior to the 1961 White House Conference on Aging.

(e) Encourage increasing cash benefits to those receiving Old Age Assistance.

(f) Exploring the possibility of including under OAA the "marginally indigent" person who is independent except for unusual trouble; and considering OAA as a possible mechanism for sharing of the premium cost of voluntary health insurance.

(g) Possible establishment of a privately financed plan comparable to the Federal Deposit Insurance Corporation (which guarantees bank depositors against loss) which would guarantee health insurance premium payments, in whole or in part as need dictates, for those over 65 who are unable to keep up such payments.

(h) Encourage pilot program for the construction of model housing units for the aged near a medical school so that scientific study could be given to the needs of the aged by faculty members. This could be done by private enterprise under present liberalized mortgage laws for this type of construction.

(i) Encourage an educational program calling for preretirement planning beginning at age 45.

(j) Place emphasis on a preventive medicine program to include periodic health appraisals; gathering of health data, control of communicable disease, improving patient care and rehabilitation in nursing homes through licensure, and the developing of chronic disease hospital units.

9. General meeting at Annual Session. In order to cut down the great number of meetings during the MSMS Annual Session, The Council recommends that a short General Meeting of the Society entitled "Officers Night" be held during the last meeting of the House of Delegates, which arrangement would be in accordance with the Bylaws, Chapter 8, Section 1. New officers will assume the responsibilities of their respective offices on this occasion.

A recommendation on this subject follows.

10. At the Annual Meeting of The Council in January, A. E. Schiller, M.D., Detroit, resigned as Council Chairman, due to health reason, but remained Councilor of the First District. H. J. Meier, M.D., of Coldwater, was elected as Chairman.

C. N. Hoyt, M.D., Port Huron, resigned as Councilor of the Seventh District effective September 26, 1960.

11. The fifty-five component societies continued during the past year to conduct necessary programs of in-service education and to provide leadership in community programs and communications to the public.

A recommendation on this subject follows.

12. As in the past, your State Society continued to render service to its components in obtaining speakers for meetings, giving advice on scientific, legal, and socio-economic questions, and in helping to solve administrative and ethical problems.

Contacts With Governmental and Voluntary Agencies

More and more the Michigan State Medical Society finds that contacts with both governmental and voluntary agencies are important though time-consuming activities.

Governmental Agencies

1. Prior to its public release, the University of Michigan Study of Hospital and Medical Economics (including Blue Cross-Blue Shield Plans) was previewed by MSMS representatives on June 29. This Study is being carried out at the request and with the approval of MSMS. It is financially sponsored by the Kellogg Foundation at a cost of $380,000.00.

2. The Council was ably represented at the Michigan Insurance Commissioner's Hearings in Detroit on May 24, 1960, and in Grand Rapids on May 27, 1960, at which the Blue Shield request for a rate increase was heard. The affirmative position taken by the State Society ably counteracted the aggressive stand of opponents of the rate increase and resulted in good publicity for the medical profession.

3. The proposal of the Michigan State Board of Pharmacy to permit the substitution of generic name drugs for trade name drugs was given considerable attention and resulted in this advice given by The Council to the State Board: "Because current practice permits substitution of drugs upon the individual approval of the prescribing physician, the Michigan State Medical Society does not believe the proposed rule of the Michigan Board of Pharmacy is necessary and supports the statement previously made by the former Chairman of the MSMS Council, A. E. Schiller, M.D."

4. Youth: the White House Conference on Children and Youth was attended by an official MSMS representative (Robert M. Heavenrich, M.D., of Saginaw, Chairman of the MSMS Child Welfare Committee) whose report indicates the importance to Medicine of this great gathering of interested personnel held every ten years at the call of the President of the United States.

5. Aging: the forthcoming 1961 White House Conference on Aging, also called by the President of the United States, has been preceded by Regional Conferences in this State as well as by the annual U-M Conference on Aging held in Ann Arbor last June. MSMS representatives testified at these planning conferences.

Official representatives of the Michigan State Medical Society also testified at the Senator McNamara Hearings on the Aged in Grand Rapids, November 16-17 and in Detroit, December 10-11; subsequently the State Commission on Aging requested MSMS to appoint an Advisory Committee to the Commission which was done.

6. The new printed revision of the Uniform Fee Schedule for Governmental Welfare Agencies was developed by the House of Delegates Permanent Advisory Committee on Fees and was distributed to all governmental agencies and personnel in December, 1959.

7. The attempt to open hospitals in the Wayne County area which are organized under the Community Hospital Law, to other than doctors of medicine was opposed by the Wayne County Medical Society and the State Society.

8. Questions of chiropody practice in Michigan resulted in the appointment of a special Ad Hoc Committee Concerning Practice of Chiropody. An early meeting of this MSMS Committee is planned with the Michigan State Board of Chiropody to receive such information as the Board wishes to present to the Michigan State Medical Society and to the Michigan Hospital Association.

9. The State Society took exception to the program of the U. S. Senate Committee Investigating Drugs, objecting that the scientific viewpoint was inadequately represented at these Hearings.

10. At the invitation of the Michigan State University, an MSMS representative attended several meetings to hear reports from MSU concerning its proposed third medical school; to date, these meetings have been merely exploratory in nature.

11. Your State Society continues to have beneficial contacts with other governmental agencies including (a) the Michigan Legislature and its bureaus and committees; (b) Michigan Department of Health with Commissioner A. E. Heustis, M.D., invited to all meetings of The Council; (c) the University of Michigan Medical School and Wayne State University College of Medicine with the Deans of each being invited to all meetings of The Council; (d) Michigan Crippled Children Commission; (e) Michigan Department of Public Instruction and its Office of Vocational Rehabilitation which refers many questions to the MSMS Arbitration Committee; (f) Michigan Department of Social Welfare; and (g) Michigan State Board of Registration in Medicine.

Voluntary Agencies

1. Monthly reports on the progress of Michigan Medical Service are made to The Council by President G. Thomas McKean, M.D.

2. Continuing coverage for spouses of deceased MSMS members in the Physicians Group Contact was recommended to Blue Cross by The Council. Michigan Hospital Service reported that, as much as it would like to make an exception for the spouses of MSMS members, its Executive Committee felt MHS would be subject to high criticism by other groups when it became known that this exception was made. If MHS adopted this policy in the future, it felt it must be granted to all covered groups.

3. The American Medical Association continues to be most helpful in numerous ways to your State Society and merits the interest and constant support of every MSMS member. The AMA is to be congratulated on sponsoring its Civil Defense Conference of November 7-8, a pre-planning Conference on Aging, April 22-23, the AMA Public Relations Institute, September 1-2, several legislative conferences, and its National Congress on Prepaid Health Insurance of May 13-14 on which the three MSMS representatives presented an excellent report to The Council May 18.

4. MSMS continues to encourage the Student Ameri-

can Medical Association on the national level and through its two Units in the medical schools of Michigan. More guidance by individual doctors of medicine for the future physicians of the nation is needed and earnestly invited.

5. Contacts with the Visiting Nurses Association included the MSMS recommendation that the VNA continue to be utilized by social welfare departments and be paid from public assistance funds.

6. An MSMS representative attended the National Blue Shield Professional Relations Conference in Chicago and presented a fine report to The Council on May 18.

7. Mutually beneficial contacts continue to be maintained with the Michigan Heart Association, Michigan Hospital Association, Michigan State Dental Association, Michigan State Nursing Association, Michigan League for Nursing, Michigan State Pharmaceutical Association, Michigan Hospital Service, Michigan Medical Service, Michigan Branch of Health Insurance Council, Michigan Health Officers Association, and the growing Michigan Association of the Professions now numbering 3,326 members.

Committees

A total of ninety-three meetings of Committees of the House of Delegates, of MSMS, and of The Council were held during the past year (up to August 31, 1960). This does not include nine meetings of liaison committees to which MSMS sends official representatives. The core of MSMS progress is its committee structure and activity and the members who make up these important groups deserve unqualified praise for their unheralded contributions to the State Society and to all members.

Special commendation goes to the Relative Value Study Committee which during the past year held seven meetings encompassing 11 days (mostly Saturdays and Sundays), which took these busy medical practitioners from busy practices in their home communities.

To save the time of the House of Delegates Reference Committees, the Annual Reports of Committees of The Council are integrated into this Annual Report of The Council:

1. *Permanent Conference Committee with Michigan Hospital Association, Michigan League for Nursing and Michigan State Nurses Association.*—There was general agreement that the number of regular meetings could be reduced without interfering with the efficiency of the combined committee. It was further agreed that special meetings could be called, if necessary, at the direction of the general chairman. The meetings were well attended by the representatives of the different component groups. The Statement of Purpose and Organization of the Permanent Conference Committee was redefined. Reports on legislation were discussed as was the report on the Institute of Nursing Practice. A study on the utilization of practical nurses is to be carried out with benefit to all groups. It was agreed that a unified effort of all groups through their public relations counsel or representative would bring about a better educational program to keep the public informed on health care needs. The Blood Test Bill, concerning alcoholic contents of blood, was also thoroughly discussed and recommendations were made.

There was also some discussion during the year concerning personnel policies. Cognizance was also taken of the fact that the government is withdrawing its support from certain schools for practical nursing.

2. *Michigan Chairman of the Medical Education Foundation.*—It is encouraging to note the $10.00 voluntary contribution to the A.M.E.F. asked of each member, produced $18,736.23 last year. This is a 71 per cent increase over the $10,874.83 donated in 1958. Also, the number of contributors increased to 499 which is twice as many who gave the year before. Still this represents only 8 per cent of our membership, and places us forty-first among the other states in the percentage of contributors. In the total amount given we stand fourteenth.

In direct gifts to our medical schools, Michigan received $49,621.77 from 1,279 contributors and Wayne received $17,616.00 from 356 individuals. Our neighboring states, Indiana, Ohio, Illinois, and Wisconsin, all have a higher percentage of their membership who contributed. Indiana, with a $10.00 assessment and a smaller membership than ours, produced $51,661.00. Illinois, with a $20.00 assessment, produced over $200,000.00.

In view of the fact that only 8 per cent of our membership made a contribution, I believe the only fair method that will produce Michigan's fair share of the monies needed for medical education is through an increase of $10.00 in dues earmarked for the AMEF. This would produce approximately $64,500.00 which represents more nearly what the physicians of Michigan should contribute to the AMEF.

3. *The Liaison Committee with the Michigan Chapter of the Health Insurance Council.*—There have been three meetings since this Committee was established; April 29 and December 16, 1959, and May 4, 1960. Many matters of mutual interest were discussed, including three specific problems involving Physicians and Insurance Companies which were satisfactorily solved. Uniform Claim Report Forms and suggestion that County Mediation Committees help arbitrate any problems arising were recommended to The Council and were approved by it. The ground work for future action on Forand-type legislation has been laid and mutual responsibility acknowledged. Periodic meetings are planned.

4. *Rural Medical Service Committee.*—The Committee met February 3, 1960. The program of the National Rural Health Conference to be held February 25 to 27, in Grand Rapids, was reviewed and the members of the Committee volunteered to take an active part in stimulating attendance to this National meeting.

Some difficulty has been encountered in obtaining a Committee from the Society of Architects to meet with the Committee from this group, but this we are told has now been formed and is available for consultation for clinic and hospital buildings.

The Placement Program was reviewed, and it was pointed out that during the past 6 years, 345 doctors have received assistance in locating in Michigan. The Upjohn Company is still providing financial assistance to the Michigan Health Council for this Program.

Plans were discussed and set up for the Michigan Health Conference in 1961.

The Medical Careers Program was reviewed and considerable progress has been noted. There was a motion that each county society be requested to designate a committee to co-operate with high schools in the county during Career Days. It seems important that the doctors urge an opportunity to be heard at "Career Day Programs."

A Scholarship Loan Fund for Medical and Allied Students was discussed. This will be investigated further. The motion that the Michigan Health Council continue its fine efforts to establish a Scholarship Student Loan Fund for Health Career Students and other activities that will alleviate the shortage of students entering medical training and allied health professions was carried.

5. *Committee on Arbitration.*—The Arbitration Committee of the Michigan State Medical Society met on April 8, 1960, to consider two cases which were submitted by the Office of Vocational Rehabilitation, one involving reconstructive surgery to muscles and tendons of hand and the other a stapesdectomy. Five members of the Committee were present at the meeting and unanimously agreed that in both cases the fees were fair for the services rendered.

6. *MSMS Representatives: Liaison Committee to Michigan Society of Neurology and Psychiatry and Michigan Psychological Society.*—No meeting between the Liaison Committee and the Michigan Psychological So-

ciety took place during this past year. Inasmuch as some members of my Committee, as well as myself, are also members of the MSMS Committee on Mental Health, we have been kept up to date regarding the developments in the particular issues involved.

7. *Committee on Courses on Medical Economics and Ethics.*—We have had a most successful year, and pay ready tribute to the co-operative endeavors of the committee members, the speakers, the faculties and student bodies of our two medical schools.

Through the energetic leadership of Dean Scott, Professor Orten, and the Senior Medical Students, Howard Shapiro, Wayne State University Medical School, is now actively participating in our program. We have blended their lecture courses with the University of Michigan schedule of activities, giving special mention whenever the event occurred in Detroit.

Activities Schedule

1. 7/8/59, "Development of a Fee Schedule," by C. Howard Ross, M.D.
2. 7/15/59, "Professional Management," by Robert Kanuer and Tim Hogan.
3. 8/12/59, "The Doctor in Court," by Judge James R. Breakey, Jr.
4. 8/19/59, "Medical Replacement in Michigan," by R. W. Spalding, M.D.
5. 9/2/59, "Continuing Education in Medical Ethics and Economics," by William Hubbard, M.D., Dean, University of Michigan Medical School.
6. 9/16/59, "The Morality of Surgery," by Thurston Thieme, M.D.
7. 9/23/59, "The Doctor's Accounting System," by C. Howard Ross, M.D.
8. 10/14/59, "Ten Easy Lessons on How to Land in Court," by Lester P. Dodd, Attorney, MSMS
9. 11/6/59, "A History of Ethics," Student Faculty Assembly at Wayne State University Medical School, by C. Howard Ross, M.D.
10. 11/18/59, "Medical Manpower," by Albert Furstenberg, M.D., Dean Emeritus
11. 11/25/59, "A History of Ethics," by C. Howard Ross, M.D.
12. 12/4/59, "An Ethical Approach to Cancer in Geriatrics," Student Faculty Assembly at Wayne State University Medical School, by C. Howard Ross, M.D.
13. 12/6/59, "Fellow Practitioners and Sub-standard Healers," Student Faculty Assembly at Wayne State University Medical School, by Milton R. Weed, M.D.
14. 12/9/59, "Solo Versus Partnership," by Tim Hogan.
15. 12/16/59, General Practice Panel:
   (a) "Moderator with Introduction," by C. Howard Ross, M.D.
   (b) "General Practice in a Metropolitan Area," by Russell Fenton, M.D.
   (c) "The General Practitioner and the Specialist," by F. P. Rhoades, M.D.
   (d) "Consultation Techniques," by A. C. Stander, M.D.
   (e) "Art of the Practice," by C. E. Wheatley, M.D.
   (f) "Medical Organization," by E. Clarkson Long, M.D.
   (g) "The Family Physician's Place in the Community," by M. H. Miller, M.D.
16. 1/13/60, "Fellow Practitioners and Sub-standard Healers," by Milton R. Weed, M.D.
17. 1/20/60, "An Ethical Approach to Cancer in Geriatrics," by C. Howard Ross, M.D.
18. 1/22/60, "The Doctor As a Witness," Student Faculty Assembly at Wayne State University Medical School, by Judge Victor Baum.
19. 1/27/60, "Ethics Involved in George Washington's Death," by Darrell Campbell, M.D.
20. 2/5/60, General Practice Panel: Student Faculty Assembly at Wayne State University Medical School.
   (a) "Moderator with Introduction," by C. Howard Ross, M.D.
   (b) "General Practice in a Metropolitan Area," by Lyle Korum, M.D.
   (c) "The General Practitioner and the Specialist," by E. Hamilton, M.D.
   (d) "Consultation Techniques," by E. S. Woodworth, M.D.
   (e) "General Practice—The Keystone," by Howard Rees, M.D.
   (f) "Art of the Practice," by Charles M. Burgess, M.D.
   (g) "Medical Organization," by E. Clarkson Long, M.D.
21. 2/10/60, "A Doctor Walks Among Many Religions," by Winslow G. Fox, M.D.
22. 2/17/60, "The Surgeon and His Fee," by Charles G. Child, M.D.
23. 2/24/60, "The Ethical Problems of Contraception and Therapeutic Abortion," by Drs. William Hubbard, Norman F. Miller, and C. Howard Ross.
24. 3/9/60, "Medical Records and Taxes," by Robert Kanuer.
25. 3/16/60, "The Physician and Society," by Ralph Rabinovitch, M.D.
26. 4/1/60, "Beginning Practice," Student Faculty Assembly at Wayne State University Medical School, by Nelson Young.
27. 4/20/60, "Orientation Committee, Washtenaw County Medical Society," Drs. Edmund S. Botch, R. Wallace Teed, Theodore G. Kabza and Gerhard H. Bauer.
28. 5/11/60, "An Outward Expression of the Michigan State Medical Society," by Kenneth H. Johnson, M.D., President Elect. A rapid-fire question and answer period included the problems of health insurance for the aged.
29. 5/18/60, Panel on Medical Communication:
   (a) "Legislative Problems," by Richard Philleo.
   (b) "Public Relations," by Wallace Teed, M.D.
   (c) "Physician-Patient Relation," by C. Howard Ross, M.D.

8. *Liaison Committee with Michigan State Board of Registration in Medicine.*—One meeting of this committee was held during the year. Problems and policies of mutual interest to the profession, the medical schools and the State Board of Registration in Medicine was discussed. It was mutually agreed that when any matter involving the concern of one or more of the groups arose, the committee would immediately be called into session for discussion of the problem.

9. *Committee on Blood Banks.*—The Committee on Blood Banks has not met during the past year mainly because, since the Michigan State Medical Society has co-sponsored the Michigan Association of Blood Banks, most of the business pertaining to blood banking has been handled by this organization due to its close relationship with the American Association of Blood Banks.

The State of Michigan is leading the way in the United States in presenting Blood Bank Workshops for the training of technologists in this specialized field and also the National Inspection and Accreditation of Blood Banks Program had its start in Michigan and is being continuously supported and carried out in this State.

Although it would sound as though the Committee on Blood Banks is non-active, it should be maintained at the state level so that there are formal lines of communication between the state blood banking association and the State Medical Society.

The Michigan State Medical Society and the State of Michigan can be justly proud of the Michigan Association of Blood Banks which has grown since its co-sponsorship by the Michigan State Medical Society and the Michigan Pathological Society into one of the most outstanding blood bank associations in the United States.

10. *Liaison Committee with State Bar of Michigan.*—No matters were referred to this committee during the

year, either, by the Michigan State Medical Society or the State Bar of Michigan. So no meetings were held.

11. *Committee on "Big Look."*—The Big Look Committee has met on four occasions during the year. At its meetings, the following matters concerning the new MSMS headquarters building were considered:

Furnishing of New Headquarters.—The Committee directed the interior design in co-operation with consultants from office of Architect Yamasaki & Associates. The specifications stressed funtionalism and reasonable cost and all contracts were awarded to the lowest bidder.

Landscaping.—The Committee selected a registered landscape architect to draw specifications for the planning of the grounds of the new headquarters. These specifications will be given final approval by the Committee and competitive bidding among landscaping contractors will follow.

Sale of 606 Townsend.—Although several offers have been made to purchase the present MSMS headquarters, none of these have been accepted by The Council. Negotiations are continuing with two prospective buyers.

Acquisition of Frost Property.—Effort has been made during the year to obtain the Frost property adjoining the new headquarters north lot line. This land is desirable both as an investment and also as a "buffer State" with the property owners to the north. MSMS now holds first option if the Frosts decide to sell.

12. *Medical Care Insurance Committee and Subcommittee on Relative Value Scale.*—The MCIC Committee held meetings January 20, March 16, April 20, and June 1 of 1960. It is anticipated that meetings will continue to be held every month until the House of Delegates convenes in September, 1960.

The Committee has devoted its major efforts to the development of a $6,500 ceiling contract as directed by the House of Delegates in September of 1959.

A secondary item of consideration was the financial problem of Blue Shield which resulted in a request to the Insurance Commissioner for an increase in premium rates.

The Committee has approved unit values for the $6,500.00 contract when it is developed.

13. *Relative Value Scale Sub-Committee Report.*—The Relative Value Scale Committee was created to develop a relative value scale for Michigan.

In the first meetings, it developed an over-all plan of operations, and condensed and modified the California questionnaire. The Committee sought experts' advice and statistical consultants and chose Market Opinion Research Co. and Dr. J. M. Mattila of Wayne University.

It was understood that a 75 per cent or smaller return of questionnaries sent to all MSMS members would not be statistically valid. Therefore, to insure a valid return, the sampling technique was employed. Market Opinion Research Co. and Dr. Mattila chose the "Sample Members" by geographical area, type of practice and numerical distribution. The identification of those "Sample Doctors" was known only to them and was never known to any committee members or any member of MSMS. The questionnaire was mailed in November, 1959, to every member of MSMS and three follow-up letters also were sent. Later the Market Opinion Research Co. did local follow-ups through their representatives in order to concentrate on "Sample Members." The return from the entire membership was 45.6 per cent; the return from the scientifically selected sample was 60.1 per cent.

The data obtained were transferred to IBM cards, were sorted, and analyzed and then presented to the RVS Committee. Validity and statistical accuracy has been certified by Dr. Mattila, the consultant. Since this report has been received in April, 1960, the RVS Committee has started the tremendous task of holding liaison meetings with group and society representatives to develop the interpolations between the milestones obtained from the questionnaire survey.

Meetings have been held on April 24, May 8-9, May 21-22, and June 4-5. About half of the groups have been contacted to date, but dates for the remainder will be harder to schedule. After these conferences are concluded, the Committee itself will require numerous meetings to complete the task. The Committee believes that this phase of the work cannot be rushed and regrets that the final report will not be ready for the 1960 MSMS meeting. The Committee has had excellent co-operation from all the special groups it has conferred with thus far and believes that its final report may be ready before March 1961.

* * *

The reports of meetings of liaison committees to which the Michigan State Medical Society sends representatives, were presented monthly to The Council for its information.

Legal Matters

Your Legal Counsel, Lester P. Dodd, LL.B., gave considerable time during the past year in providing necessary legal advice to the Michigan State Medical Society, many of its committees, and to component societies. He held numerous informal conferences with our committee chairmen, with component societies' officers, and with the MSMS staff.

Again, as last year, the details of building the new MSMS headquarters also threw additional burdens of research and decision on Mr. Dodd.

Legal opinions or specific guidance were rendered by Mr. Dodd on the following matters:

(a) Opinion re surgical privileges in an accredited hospital

(b) Opinion on Michigan Supreme Court decision concerning statutory rule pertaining to privileged communications

(c) Opinion re medical problems in hospital

(d) Opinion re drawing of blood for alcohol determination

(e) Opinion re legal limits of chiropody practice

(f) Opinion re validly authorized post-mortem examination

(g) Opinion re problems involved in utilization of practical nurses in administration of drugs and medication. Also re legality of nurse administering anesthetic on a fee-for-service basis if not under supervision of an MD

(h) Opinion re liability of physician who volunteers for emergency call service at local hospital

(i) Opinion re permission to do surgery on children when parents are under age 21

(j) Opinion whether total health and accident premiums could be regarded as a medical deduction for income tax purposes—only the health insurance portion is deductible

(k) Opinion re patient refusing psychiatric treatment —improper to bring in consulting physician or refer patient for psychiatric treatment without consent of patient

(l) Opinion that county society mediation committee is only body of county society that can hear outside representatives and that insurance companies and private individuals should have free access to advice of these committees

(m) Opinion re propriety of a physician or hospital divulging information concerning bills

(n) Advice re internal revenue service proposed rules and regulations on Kintner-type associations, permitting pension plans in special group practice situations

(o) Comment re doctors belonging to labor unions.

New MSMS Headquarters Building

The cornerstone of the new MSMS building at 120 West Saginaw Street, East Lansing (M-78 and Abbott Road), was laid with appropriate ceremonies on Sunday, September 27, 1959, with the Officers, The Coun-

cil, many members, and Architect Minoru Yamasaki present.

At every monthly meeting of The Council, progress on the erection of the new building was presented by the Lansing representative of the Big Look Committee, President-Elect K. H. Johnson, M.D., including furnishings, new equipment, and sale of the 606 Townsend property.

The original estimate for occupancy was necessarily postponed by the steel strike which forced delay in prefabricating the concrete vaults and pillars; also an iron workers' strike stopped activity this spring for thirty-five days. Construction was resumed on June 27. The present conservative estimate for occupancy is December 1.

Through the commendable efforts of Treasurer Wm. A. Hyland, M.D., a line of bank credit has been established, at a favorable rate of interest, to pay for completion of the building pending receipt of dues allocation which may necessarily run through the year 1966 to fully pay for the building.

Plaque and donor tablets, to memorialize those individuals, or families, who contribute toward furnishing specific rooms, have been authorized; in addition, a memorial volume to record these and other donations will be a permanent fixture in the lobby of the MSMS headquarters.

Some special gifts already have been received and plans are being formulated to obtain additional contributions to supply necessary equipment for new extended services to be rendered by MSMS to its members and the public.

The Big Look Committee, headed by Past-President W. S. Jones, M.D., has done yeoman service to the Society during the past year in connection with the erection of the new MSMS headquarters building.

MSMS Group Insurance Programs

A complete report on the two group insurance programs of the Michigan State Medical Society will be presented in the Supplemental Annual Report of The Council, with data up to September 1.

"Medicare" and Veterans Administration Hometown Medical Care Programs

1. Due to service cutbacks, Medicare payments were less in 1959 than in previous years. However, some of the services were restored on January 1, 1960, which increased private practice of medicine under the program. Medicare is being handled by Michigan Medical Service as fiscal agent of the Michigan State Medical Society; it appears to be a program that so far has been satisfactory to both patients and the purveyors of service.

2. Veterans Administration Hometown Medical Care Program. During the past year minor changes in the program were made, acceptable to MSMS. The new contract went into effect April 1, 1960 and was approved by MSMS—the attitude of The Council, in renewing the modified contracts has not changed since its report to this House of Delegates last year: "Unless the program for care of veterans is much improved, MSMS seriously considers discontinuing its participation."

Woman's Auxiliary

(Submitted by MRS. HAROLD GAY, Coleman, President)

As President of the Woman's Auxiliary to the Michigan State Medical Society I take pardonable pride in submitting this report for the year 1959-60.

Before citing Auxiliary activity, however, I should first like to thank Mr. Burns and his efficient staff for the work and courteous assistance they have given us for so many years. Without these services we would be in serious difficulty.

We are especially appreciative of the labor and financial support extended in the publication of the *Auxilium* and regret only that it must be limited to three instead of four issues.

For the recognition and praise of Auxiliary accomplishments expressed by your President, Dr. Darling, in his President's Page of THE JOURNAL, we wish to say "Thank you, Doctor Darling."

Though there has been no instance this year which required consultation with the advisory board, we are grateful for its letter of suggestion sent to all county medical societies, urging the utilization of Auxiliary talents in many areas of public relations. Although the number of Auxiliaries cooperating with the county medical societies seems to be increasing, the results of this communication will not be evident till next year.

Election years are apt to be both exciting and interesting, but this year has been exceptionally so with its Forand Bill, McNamara hearings, and consequent conferences on the needs of the aged. It has been a tremendously busy one for all our state officers and chairmen who have given so willingly of their time and energies to promote Auxiliary goals and translate the principles of the practice of medicine to the public.

Legislation has received foremost Auxiliary attention this year because of the recurrent threat of socialized medicine. All District meetings, the mid-year Board meeting and one issue of the *Auxilium* were given over to alert and inform members with regard to the dangers of the Forand Bill. Auxiliaries sent resolutions, individuals wrote letters protesting the bill, and its emergence from committee. Through efforts of individual members who spoke to other organizations many more protesting resolutions and letters were added to the flood of correspondence in Washington. The resolution from our State Auxiliary was made part of the congressional record. We pause in our efforts now to await further instruction for proceeding in this fight which has only begun.

Our Auxiliaries have supported the AMEF project to the amount of $6,492.58 which seems like a substantial sum until one hears what is being done in the neighboring states. This, however, is an increase of $1,000 over last year and we believe that as understanding of the need and use of AMEF funds grows, so will the Michigan contribution.

Our recruitment program is well known to you and continues to flourish independently and in cooperation with other organizations such as the League for Nursing. Most of our counties sponsor future nurses clubs and offer nurses scholarships and/or loans. This project is particularly attractive to our Upper Peninsula counties. One Auxiliary reports sponsoring a Future Doctors Club through the Kiwanis Club.

We are now urging that recruitment efforts be extended to include the whole paramedical field. In cooperating with the Michigan Health Council, an opportunity highly valued, the Auxiliary this year helped to promote paramedical careers recruitment through the Regional Rural Health Conferences held in Marquette, Kalamazoo, Detroit, and Mt. Pleasant. We also furnished a table top exhibit at the National Rural Health Conference in Grand Rapids.

The total amount offered by the county auxiliaries for scholarships and/or loans is over $12,000. Two counties report scholarships for medical students. The State Auxiliary is one of the planners with the Michigan Health Council which hopes to set up a State Scholarship and Loan Fund for recruitment in the paramedical services.

Of all our projects, our Mental Health program has shown the greatest growth this year. The use of Milestones to Marriage in both schools and churches is gaining popularity. Through the initiative of our Mental Health Chairman sample drugs, valued at $9,000, have been collected and sent to the State Mental Hospitals. Operation Friendship, remembering the forgotten State and County hospital patient on seasonal holidays and birthdays, is favored by some auxiliaries. The program has been extended also in cooperation with other or-

ganizations. Auxiliaries report programs on alcoholism, problems of our senior citizens, emotional needs of children, Industrial Mental Health, etc. The collection of toys for State Home and Training Schools and sending gifts to County Hospitals are additional activities in promoting better mental health.

It is difficult to draw the line between these projects and community service, since all Auxiliaries adapt the program to their community needs. Community service is the province of the individual member as well as the whole auxiliary and covers a wide range of endeavor such as volunteer hospital work, county immunization programs, blood banks, cancer registry, T.B. survey, health booths at State and County Fairs, Red Cross instruction, youth leadership, Science Fair promotion—just to mention a few.

One member conducts a school for deaf children and speech defectives from the ages of two to six. She is assisted by two other doctors' wives and draws children from a tri-city area. One Auxiliary with its medical society honors, at a tea, students graduating with high scholastic ratings. Time and space prevent a complete listing of such activity.

In the rural areas where leadership is at a premium, the doctor's wife is called upon to participate in all types of community action. Through her social contacts she acts as a liaison between the public and the medical profession—an ambassador of good will. It is in this service that our Michigan Auxiliary members make their greatest contribution to Auxiliary ideals and to the Medical Association. This is why it is imperative that the county medical society should keep its auxiliary well informed concerning its views and policies about which the public should know.

Because the State of Michigan has a well developed Safety and Civil Defense organization, Auxiliaries initiate no action. They do cooperate in the community program and usually schedule an informative program concerning these subjects during the year.

Not to be overlooked is our fine relationship and cooperation with the Student AMA Auxiliary. Representatives from these groups are guests at our Mid-Year Board and Annual Sessions. They are well indoctrinated and will enter their communities well aware of existing problems and with some ideas of approaching them.

Membership-wise we show a slight increase. But the small auxiliary scattered over several counties as well as the large metropolitan auxiliary continue to be problems—the former, too vague and lacking in motivation, the latter too impersonal. We are still looking for the magic formula which will solve the situation and bring every doctor's wife within the fold.

So, for its thirty-fourth year, the Woman's Auxiliary to the Michigan State Medical Society has followed the aims laid down at its inception, chief of which are:

1. Through its members to explain the objectives of the medical profession to lay organizations interested in health education.
2. To do such work as may be approved or assigned by the Michigan State Medical Society.

Public Relations

Public Relations activity has been intimately involved with major projects of the Society as in the past. In addition, the varied subjects involved are indicated by the following activities of the past year.

—Nomination of Arthur A. Claytor, M.D., for the AMA General Practitioner of the Year Award.

—Work with science writers and other newspaper representatives.

—Assistance to the Medical Assistants.

—Work with county medical societies, Woman's Auxiliary, Medical Assistants and others in presenting exhibits at the State Fair, the Saginaw County Fair, the Upper Peninsula Fair, the Ionia Free Fair and many community fairs or their equivalent.

—Planning and implementation of complete publicity programs in connection with the Annual Session and the Michigan Clinical Institute, including TV, radio and newspaper, plus special presentations before service clubs, women's clubs, etc.

—Special TV programs on such subjects as medical care of the aged, the role of the family doctor, etc.

—Directional and cooperative services in connection with four major Regional Health Conferences.

—Similar services were rendered in connection with the Congress of the Professions of which the MSMS President was Honorary Chairman and MSMS Past President George W. Slagle, M.D., was General Chairman. Held in Detroit, January 22-23, this was the first such meeting ever held in Michigan or the nation.

—Handbooks for CDMCIC members were prepared.

—Meetings on Public Relations on the state and national level—participated in both by attendance and as program participants.

—As instructed, developed recognition programs for outstanding services of members, science writers, ancillary personnel and a multitude of others by letter, scrolls, gifts, etc.

—Preparing, reviewing and revising films and purchase of prints.

—Testifying before legislative committees and arranging for testimony.

—Active liaison with the Michigan Health Council in its day-to-day operations, plus the planning and arrangements for the National Rural Health Conference at Grand Rapids—the only AMA national meeting to be held in Michigan for several years.

—Efforts to bring the national meeting of the American Association of Medical Assistants to Michigan.

—Recruiting of medical students and medical associates via the preparation of brochures, fund-raising campaigns and the holding of conferences at educational institutions and elsewhere.

—Preparing contacts with Congressmen, Public Health Officers, public officials and friends of medicine, both in Michigan and Washington, D. C.

—Planning for the County Societies-Public Relations Seminar and Editors Workshop and arranging for the program participants.

—Arranging for special information to be given to The Council on subjects of legislative interest.

—Assistance to county medical societies in programs. the awarding of honors, publicity, and any number of miscellaneous problems.

—Development of brochures for special purposes and articles for THE JOURNAL, MSMS.

—Maintenance of a Public Relations Library and distribution of thousands of publications.

Legislation

Although legislation and public relations are separate, they are bound to overlap in many ways. Thus, whereas the work on the problems of the aging were scientific, legislative and socio-economic in nature, the public relations overtones also were of major importance during the past year.

In election year 1960, when powerful organized labor and political advocates of socialized medicine were exploiting the circumstances and sympathies of the senior citizen to stimulate public support for the Forand Bill, Michigan Doctors of Medicine launched an intensive, six months' counter-attack program of public education.

Despite these efforts, however, it seemed likely at mid-year that a vote-conscious Congress would be stampeded upon its return to Washington in August into adopting some variation of the Forand Bill to provide limited compulsory health care to the aged, still within the framework of the Social Security law.

Accordingly, on July 15, the Council launched a crash program to alert the profession and through it the public to the immediate crisis confronting the nation. The Council believes that *individual doctors are capable of exerting great force to counteract such a political*

move. The crash program is designed to multiply and maximize each doctor's personal influence.

A recommendation on this subject follows.

In addition to the work on the Forand Bill and its related legislation, including formal resolutions, legislative proposals, communications, hearings, et cetera, work in legislation included such matters as:

(a) Taxes—income or sales tax, or levy on the self-employed.
(b) Optometry.
(c) F.E.P.C.
(d) Immunization.
(e) Chemical tests.
(f) Atomic energy.
(g) Retirement for the self-employed.
(h) Crippled children.
(i) Chiropractic.
(j) Appropriations for medical and health programs and projects.
(k) Registration of M.D.'s, psychologists and others.
(l) Internship and foreign doctor problems.
(m) Ambulance regulations and related activities.

These were involved in 800 bills reviewed, of which 122 were of keen interest to the medical profession.

Again, it can be said that the Legislature was most cooperative with MSMS and understanding of the wishes of the medical profession. The legislators refused to pass legislation inimical to the best health interest of the people and the profession and approved by legislative action the requests of MSMS.

Matters Referred for Action by the 1959 House of Delegates

1. *Resolution 1.* As directed, MSMS took recognition of the accomplishments of the Kalamazoo State Hospital at its Centennial celebration.

2. *Resolution 3.* Freedom of choice of contract in Michigan Medical Service: As directed, request was made to Michigan Medical Service Board of Directors to give each group purchaser of its contract, as the case may be, the option of choice of plans currently offered for sale, and that the eligibility for service benefits under income-not-certified contracts be determined by mutual agreement between the physician and the patient. Michigan Medical Service reported it had implemented this Resolution as follows: "That for group purchasers, the choice of income-certified or income-not-certified certificates will be offered to the group as a whole and that individual members of a group which selects the income-not-certified certificates may choose whichever of the four income levels offered that he desires."

3. (a) *Resolution 4* re modification of MMS M-75 to $5,000 income limit; (b) *Resolution 5* re modification of MMS M-75 to $6,500 income limit; (c) *Resolution 16* re family income determination; (d) *Resolution 42* re determining total annual family income: the substitute resolution adopted by the 1959 House of Delegates in lieu of these four resolutions was transmitted to the Board of Directors of Michigan Medical Service with request that it proceed with its implementation as directed. Michigan Medical Service reports that its Enrollment Committee has been working continuously on this substitute Resolution and will include its recommendation in its Supplemental Report to the 1960 House of Delegates.

4. *Resolution 6* re hospital committee reports, prevent subpoena: as instructed, this was referred to the MSMS Legal Affairs Committee which considered it at two of its meetings. Legal Counsel also considered this matter and was of the opinion that present Michigan laws covering the subject are sufficiently broad to accomplish the purpose of the 1959 resolution (i.e., to deny to subpoena all hospital medical staff committee reports) and that the submission of a specific bill into the legislature by the Michigan State Medical Society might be more damaging than helpful. It is to be noted that House Bill 25 of the 1960 Michigan Legislature (not introduced by MSMS) touched on the general subject, but was so broad that, in line with the 1959 House of Delegates resolution, it was opposed by the State Society. The bill died in committee.

5. *Resolution 7,* re publishing nominations for Michigan Medical Service Board of Directors, was transmitted to Michigan Medical Service with a formal request that such procedure be inaugurated. Michigan Medical Service reports that it implemented this Resolution.

6. *Resolution 8* reaffirming 1957 Statement of Principles; Resolution 21 House of Delegates to approve prepayment plans contracts; Resolution 38 MMS: Study of remuneration for prolonged and/or complicated cases; the 1959 House of Delegates presentation made by Chairman of the National Blue Shield Plans; and the Annual Report of the House of Delegates *ad hoc* Study Committee on Regional Election of MMS Board Members: these five matters were referred to the House of Delegates Committee to Work With National Blue Shield which will present its findings and recommendations in a separate report to the 1960 House of Delegates.

7. *Resolutions 10, 17, 20* re participating and nonparticipating physicians to be paid by Michigan Medical Service in same manner: the substitute resolution on this matter was referred to the Board of Directors of Michigan Medical Service with request that it incorporate on the Doctor Service Report form a statement of assignment which could be signed by the patient or subscriber when payment is to be made to a nonparticipant. Michigan Medical Service reports that it implemented this substitute resolution on December 11, 1959.

8. *Resolution 15,* re maximum term of members of the Board of Directors of Michigan Medical Service, was directed to the attention of Michigan Medical Service which reported that it had fulfilled this resolution's request so far as M.D. representatives on the MMS Board are concerned, except that the President (and members serving as representatives of the public) may be excluded from the MMS Board resolution on this subject by a two-thirds vote of the members of the Board.

9. *Resolution 18* re adoption procedures: the instructions of the House of Delegates were followed and copies of this resolution were mailed to all indicated in the House resolution.

10. *Resolutions 24, 28, and 35,* re transmitting Council minutes to Delegates and county society secretaries: minutes were and are sent monthly, as directed.

11. *Resolution 26* re Geriatrics Chairs in Medical Schools: this matter was invited to the attention of the Deans of the two Medical Schools in Michigan; their individual replies indicated a willingness to institute such a department but they both pointed out that more money from the Legislature is necessary if they are to do so. In discussing this matter, the MSMS Liaison Committee with Michigan Medical Schools (March 30 meeting) pointed out that more research is needed in this area before a special department can be set up and a man obtained to head it and begin a training program and that such a Chair probably would fit more appropriately in the schools' faculty under the department of internal medicine.

12. *Resolution 27.* In accordance with this resolution, the Speaker appointed a House of Delegates Committee to Study Malpractice which will report its deliberations to the 1960 House of Delegates in a separate report.

13. *Resolution 30,* re itemization of Blue Cross and Blue Shield premium notices, was transmitted to Blue Cross and Blue Shield. Michigan Hospital Service stated that "Blue Cross is eager to have subscribers know what the relative cost of the two services is insofar as it is practical to do so . . . that certain steps already have been taken to provide this information to some of our subscribers who receive individual monthly bills. So far, we have not been able to think of any practical way to make group subscribers on payroll deductions aware of the individual Blue Cross-Blue Shield costs on a monthly

basis since they never see any bill at all."

14. *Resolution 31*, re prenatal health program of Michigan Department of Health was referred to the MSMS Maternal Health Committee by the 1959 House of Delegates: the Maternal Health Committee reviewed the material in the prenatal letters, as prepared and mailed by the Michigan Department of Health, and found no objectionable material therein; since the program began in 1920 and the letters are sent on request of the attending physician except in rare instances, the Maternal Health Committee recommends the continuation of the Michigan Department of Health Prenatal Letter Program, and that the letters be sent patients only on the request of the attending physician.

15. *Resolutions 33 and 34*, Editor to be elected by House of Delegates, was referred to the Special House of Delegates Committee to Study Michigan State Medical Society Publications; the Annual Report of this Committee will be presented to the 1960 House of Delegates.

16. *Resolution 36*, Civil Defense Training Programs: a copy of this resolution was sent to the secretary of every component society, as per instruction.

17. *Resolution 37*, re medical student recruitment: each component society was encouraged to appoint an active committee delegated with the responsibility of continuous presentation of the advantages inherent in medicine as a vocation; in addition, the Michigan Health Council included this activity as one of its major projects of the year.

18. *Resolution 39*. Other professions: reduced fees to senior citizens. This was referred to the Board of Directors of the Michigan Association of the Professions which invited the problems created by an aging society to the attention of its member-organizations (law, dentistry, engineering, architecture—other than medicine) and urged each profession to study the matter and make necessary decisions so Michigan will lead the way in a progressive program in this important subject area.

19. *Resolutions 44, 45, and 52*, re voting privileges and election of Secretary and Treasurer. These proposed amendments to the Constitution, recommended by last year's Reference Committee on Constitution and Bylaws, are on the agenda for consideration by the 1960 House of Delegates.

20. *Resolution 51* re membership on Postgraduate Medical Education Committee: this matter was studied by both the MSMS Postgraduate Medical Education Committee and the House of Delegates Committee on Committees; the latter Committee will submit its recommendations on this and other matters to the 1960 House of Delegates in a separate report.

Recommendations

1. That the House of Delegates give approval to the President's Program and urge enthusiastic support of this important project by all members.

2. That The Council be authorized to arrange Councilor Conferences, prior to the Annual Session, to continue communication and share information with delegates, alternate delegates, and component society officers, as during the past three years.

3. That the House of Delegates give fitting recognition to the first Michigan lady to become President of the Woman's Auxiliary to the American Medical Association—Mrs. W. L. Mackersie.

4. That the House of Delegates approve the holding of an annual "General Meeting" of the State Society as part of the last meeting of the House of Delegates.

5. That component societies be encouraged to sponsor "County-State Society Nights" once per annum, to augment communication and information on matters vital to the full memberships of all county societies in Michigan.

6. That the House of Delegates approve amendment to the Bylaws (Chapter 10, Section 1) to confirm the traditional practice of electing the officers of The Council in September, immediately after the election of new Councilors by the House of Delegates.

7. That the House of Delegates reactivate the MSMS Cancer Control Committee by approving amendment to Bylaws (Chapter 11, Section 3), as the guidance and advice of this committee is necessary at this time.

8. That The Council be authorized to send MSMS representatives to Washington, D. C., in 1961 on the occasion of the Annual Michigan Day, as recommended for many years by the House of Delegates.

9. That the House of Delegates endorse the action of The Council in developing and implementing an intensified crash program against political medicine for the aged; further, that the House of Delegates urge every MSMS member to recognize the seriousness of this threat and personally to inform his patients and other friends *NOW* of the fallacies and dangers of this ill-advised program which will dilute the present high quality of medical care for *all* people.

Respectfully submitted,

H. J. Meier, M.D., *Chairman*
T. P. Wickliffe, M.D., *Vice Chairman*
A. E. Schiller, M.D.
O. B. McGillicuddy, M.D.
Wm. A. Scott, M.D.
C. Allen Payne, M.D.
H. H. Hiscock, M.D.
C. N. Hoyt, M.D.
E. S. Oldham, M.D.
D. G. Pike, M.D.
O. J. Johnson, M.D.
W. M. LeFevre, M.D.
B. T. Montgomery, M.D.
B. M. Harris, M.D.
R. J. Mason, M.D.
G. Thomas McKean, M.D.
W. W. Babcock, M.D.
William Bromme, M.D.
J. J. Lightbody, M.D., *Speaker*
H. F. Falls, M.D., *Vice Speaker*
Milton A. Darling, M.D., *President*
K. H. Johnson, M.D., *President-Elect*
D. Bruce Wiley, M.D., *Secretary*
W. A. Hyland, M.D., *Treasurer*
G. B. Saltonstall, M.D., *Past President*

ANNUAL REPORT OF ETHICS COMMITTEE—1959-1960

The committee met once this year as a group for the sake of winding up some of the year's problems. There was plenty to do and the mails served in most cases but there was a well attended meeting in the MSMS offices at 4 p.m. on May 11 to complete insofar as possible a report to the Council before the end of the fiscal year.

The Council approved all of the actions taken except one and that was on the basis of their not having enough information on that particular subject. That will be discussed a little further on under anesthesia fees.

As a sample of the problems presented, one doctor wanted to know if it would be ethical to allow the local weekly newspaper to put, at no expense to him, a professional notice giving his hours and phone numbers for the convenience of the subscribers of the paper. This is often a local custom in the smaller areas but he was new to the area and did not know that it is often done.

Another involved the receipt by a doctor of a notice from a nearby air base telling him they were accepting bids for doing eye refractions for the personnel at the base—the lowest bidder to get the contract. He had refused to enter a bid and we complimented him on his good judgment.

There were numerous similar cases but none could compare with a hassle that lasted a little more than two years and used up reams of paper and countless hours of valuable time, even involving legal talent.

In this case a doctor was suspended because of his stubborn refusal to divulge what medicines he was using in his treatment of mongoloid children. Many hearings had been held with his Society's committees according to their by-laws but he had an idée fixée that he would never reveal his medication to them until he had had a chance to give a paper on it before some national medical society.

After an unknown number of refusals, he was finally given a place on the American Association for the Advancement of Science Program late in December, 1959. He then sent his county society a copy of that paper with copies of the illustrations of patients "before and after" and detailed doses of what turned out to be mostly simple vitamins grouped under the names he had coined.

This committee then assumed that it was correct in interpreting the order of his suspension by his society's ethics committee to mean that his detailed description had fulfilled the requirements of the suspension. We asked the Council to inform the society involved to that effect. This committee also asked that the suspending society apprise us if that were true. We have had no such message to date. The minutes of the Council meeting, May 18, apparently approved this part of the report of our meeting on May 11 because only the next case was not fully accepted until the Council had more information.

The next case involves the matter of what MMS should pay for various types of anesthesia and to whom the fees should be paid. There were four possibilities: 1, with the anesthesia started and finished by an anesthesiologist; 2, where it was started by an anesthesiologist and finished by a nurse anesthetist; 3, where there were multiple anesthesias at the same hospital and all are supervised by one doctor anesthesiologist; and, finally, 4, where the doctor was called in consultation during an anesthetic being given by a nurse who needs help when a complication arises.

This anesthesia problem seemed actually not to belong to ethics as such but more to the economic side of MMS. This question probably was the reason why The Council turned this one case back before approving the conclusions drawn by the Ethics Committee and asked for more information on the subject.

All the other decisions of the committee were apparently approved.

Recently an inquiry from the AMA Disciplinary Committee in re medical disciplinary and mediation problems in Michigan was received and was at once referred to the Mediation Committee of the MSMS as promising to be a long term study in which we would be glad to help as much as possible if help were needed.

The last problem just received on June 27 from the Electroencephalographic Society asks four questions of our committee:

1. Is incorporation of an EEG laboratory ethical within the standards of the society?

2. Does the MSMS view incorporation in general as professionally ethical?

3. Are there some types of medical service that may be ethically incorporated whereas others may not?

4. Has the AMA established any standards in this regard?

And so it goes! It is obvious that the duty of this committee is supposed, by some people, to be the tackling of any problem that nobody else wants. We have been busy and there has been plenty to do this year.

Respectfully submitted,
H. W. Porter, M.D., *Chairman*
W. L. Harrigan, M.D., *Vice Chairman*
F. M. Doyle, M.D.
F. H. Lindenfeld, M.D.
J. D. Miller, M.D.
E. A. Oakes, M.D.
E. A. Osius, M.D.
A. H. Price, M.D.
P. K. Stevens, M.D.
W. F. Strong, M.D.

ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE—1959-1960

During the year just past, this Committee has curtailed its expenditures in recognition of necessary use of funds for other purposes. On the other hand, it has striven to increase its production. The result has been fewer projects but more extension of service to established media and communication through organizations.

Postponed were plans for a Medical-Legal Conference on Investigation of Unexplained Deaths, a motion picture and brochure on the cost of medical care, an exhibit at the Upper Peninsula Fair. Dropped were live surgical public telecasts and some radio programs.

In addition to the work noted in the report of The Council, and supplementing the work of many scientific and socio-economic committees, we have carried out a program designed to so inform and persuade the public that it will continue to have confidence in the practicing doctor of medicine, his organization and his philosophies.

Television and Radio: Additional "Family Doctor" television shows to those of last year were presented supplemented by appearances over established programs or on specially allocated periods. Cooperation was given to the Michigan Association of the Professions—Michigan Health Council TV program "Decision—the Moment of Truth," a program built to explain why professional people do-what-they-do-in-the-way-that-they-do-it and how to make best use of professional people. Several radio programs were originated by MSMS and participation by M.D.'s in these programs was outstanding. Continued support was given the U. of M. health series broadcast in tape over local radio stations.

Intra-Professional Liaison: Visits to county medical societies, the Upper Peninsula Medical Society and sundry specialty groups maintained intra-professional liaison. All requests for services by county medical societies or individual members were gladly received and carried out.

Motion Pictures: The documentary film on the new MSMS Headquarters is progressing nicely. Several films prepared by the AMA and other recognizably authoritative organizations were purchased.

Science Fairs: MSMS aided local medical society participation in science fairs and recognized the winner of the National Science Fair, Philip C. Bockman, from Grand Rapids.

Exhibits: An educational exhibit was made at the Michigan State Fair and we point now to the fact that last year MSMS was awarded the trophy for having the outstanding exhibit at that fair. This fact occurred too late to include in last year's report. Again thanks are due the county societies, the Auxiliary, medical students and medical assistants for their cooperation.

Michigan Association of The Professions: This organization has grown to a membership of 3,325 and has effectuated a brilliant program of service in the fields of education, public relations, legislation and business services. Of particular advantage to the medical profession were:

(a) The Congress of the Professions—Detroit, January 22-23, which held hearings on the subjects noted above and presented, among other outstanding speakers, Dr. Arthur S. Flemming, Secretary of Health, Education and Welfare and Dr. David B. Allman, Past President of the AMA.

(b) Day-long meetings to recruit students such as that held at Traverse City were students from a ten-county area were interviewed by eight deans of graduate schools, among them Dean Gordon Scott of Wayne State University College of Medicine and Assistant Dean C. J. Tupper of the University of Michigan Medical School.

(c) Legislative support of the Keogh Bill and opposition to the Forand Bill by letter and personal trip of officers to Washington, D. C.

(d) The instituting of Group Term and Major Medical Insurance programs, plus other business services such as the "new office" furnishing and equipping program.

(e) The communicating, in response to a request of the MSMS House of Delegates, of an urge to state member organizations of the need and opportunity to solve the problems of the aged.

Pamphlets: Distribution of AMA pamphlets was emphasized this year in view of the excellence of these publications. Schools, school libraries, fairs, doctors' offices, etc., served as outlets for these. In addition, the MSMS "Emergency Medical Card" and the pamphlet "Your Family Health Record" were distributed in the number of several thousand.

Public Relations Conference: The County Secretaries-Public Relations Seminar was held in January, augmented by an Editor's Workshop for publishers of county society bulletins. An excellent attendance complemented an outstanding roster of speakers.

Mass Media: By means of press releases to all Michigan newspapers, radio and TV stations, reports of current work of MSMS was carried to the general public. Also special stories were released to home-town papers of Doctors who received special honors. The work of the staff with the newspapers is a never-ending task highlighted by special work under the direction of the Press Committees at the Annual Session and the M.C.I.

Speakers Program: For the fourteenth consecutive year, a galaxy of M.D. speakers appeared before service clubs of Detroit and Grand Rapids in connection with Annual Session and M.C.I. weeks. Throughout the year, the medical profession served the schools, colleges, clubs, ancillary groups and business organizations with a steady flow of speakers on an unusually broad variety of subjects—uppermost, this year, were talks on the problems of the Aged.

Publications: Many legislative and other special bulletins were issued during the past year. Aid was given *The Auxilium*, meeting announcements, JMSMS articles and a pronounced change in the format of THE JOURNAL was accomplished. A new publication *Medical Economic Currents* was published containing capsulated and charted facts of major interest. This was sent to 1,000 MSMS members who have state and county responsibilities which place them in the position of developing policy and expressing medicine's position to the public. It is published five times each year. This publication also provided opportunity for reprinting of these charts in county society bulletins. A new *Medical Career Guide* was prepared by MSMS and published by the Michigan Employment Security Commission. The special subcommittee in charge of this project was headed by J. M. Sheldon, M.D.

P.R. Library: This growing repository of working materials continues to increase in value and usage. Adequate accommodations for it will be available shortly and it is anticipated that next year will see a vastly increased service emanating from this valuable facility.

Civic Affairs: Increased interest in civic affairs has been evidenced by county societies during the past year. Delegations of doctors to Lansing, Washington, D. C., participation in Aging Conferences, Regional Health Conferences, political parties, local "Homeramas," etc., have indicated an increasing interest by the profession in civic duty.

National Rural Health Conference: Held in Michigan for the first time, this conference attracted nationwide interest and was well attended. MSMS played an active part in obtaining this conference for Michigan and aided in the development and presentation of the program. This program, plus the Regional Conferences, replaced the annual Michigan Rural Health Conference in 1960. The Annual Rural Health Conference series will be resumed in 1961.

Presidents' Program: The Presidents' Program, to be reviewed elsewhere, is heartily endorsed as offering vast possibilities for outstanding public relations gains.

Comment: Try as the profession will, the concerted efforts of its powerful enemies (enemies not of scientific medicine but of the profession's concept of the best way to practice medicine) are making inroads in public thinking. This Committee feels duty-bound to urge increased activity (and financial support) in the future, both on the part of the individual doctor and of organized medicine.

Respectfully submitted,

R. W. TEED, M.D., *Chairman*
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A. E. SCHILLER, M.D.
T. P. WICKLIFFE, M.D.

ANNUAL REPORT OF THE PREVENTIVE MEDICINE COMMITTEE—1959-1960

The function of this Committee is to coordinate the efforts of the various committees working in the broad field of disease prevention. This function was carried out during the year.

Members of the Committee, who are chairmen of the scientific committees of MSMS, reported the activities of their committees during the past twelve months. Also, committee member A. E. Heustis, M.D., State Health

(Continued on Page 1266)

Obstetrical BREVETS



Rupture of the Uterus

Rupture of the uterus accounted for 10.7 per cent of the maternal deaths in Michigan due to direct obstetric causes during the years 1950 to 1957 inclusive.

Precipitating factors which we have found in the study of these cases include previous Cesarean section, induction of labor by pitocin, intrapartum pitocin stimulation, version and extraction, forceps delivery and spontaneous precipitate delivery. It is especially interesting to note that 27 of the 77 maternal deaths from rupture of the uterus followed spontaneous delivery, five of which were breech presentations.

Advancing parity which goes hand in hand with advancing obstetrical age is the first warning sign. Of patients who died from uterine rupture, 57 per cent were 30 years of age or older; 88 per cent were multiparous and 34 per cent were para 5 or more.

Another interesting finding was the lack of good prenatal care which was evident from the records. Of the 77 patients who died 68 per cent had either little or no prenatal care.

There are two other statistics which help in telling why death so often follows rupture of the uterus. Of the 77 patients who died, only 31 had a pelvic examination and there were but 29 hemoglobin examinations performed. These are also indications of the type of prenatal care which the patients received.

There are unpreventable deaths due to rupture of the uterus but these in modern times are rare indeed.

Prevention of rupture of the uterus has its beginning with good prenatal care. With strict adherence to the rules for pitocin induction and stimulation, the general rule once a Cesarean section always a Cesarean section, the abolishment of version and extraction as a mode of delivery, and the use of forceps only by the well-trained, the number of uterine ruptures will rapidly diminish.

To decrease the number of deaths from rupture of the uterus, blood in adequate amounts should be readily available in every hospital doing obstetrics. *Every* cervix should be inspected following delivery. *Special* consideration must be given to the multiparous patient over 30, following precipitous or breech delivery, the use of pitocin for induction or stimulation, or following any operative or traumatic delivery such as forceps, extractions, or unusual fundal pressure as would be encountered with shoulder dystocia.

Manual exploration of the uterus, carefully done, is no longer feared and is often a live-saving procedure. A warning should be stressed that frequently small ruptures are not easily detected. Consultation should be considered for patients with excessive bleeding, a rise in pulse rate, a drop in blood pressure or persistent pain in the pelvis, abdomen or flanks.

One final statistic: only 23 babies in this series of 77 maternal deaths survived.

ANNUAL REPORT OF THE PREVENTIVE MEDICINE COMMITTEE

(Continued from Page 1265)

Commissioner, discussed the activities and plans of the health department in disease prevention.

The Committee gave considerable study to the role it might play in the MSMS Presidential Program. It was felt that the Preventive Medicine Committee could, through its members, serve as a coordinator of activities and projects of the various scientific committees. The Presidential Program to add useful years to life during a five-year educational effort, was enthusiastically received. More detailed planning is scheduled for future meetings of the Committee.

Respectfully submitted,
B. M. Harris, M.D., *Chairman*

B. E. Brush, M.D.
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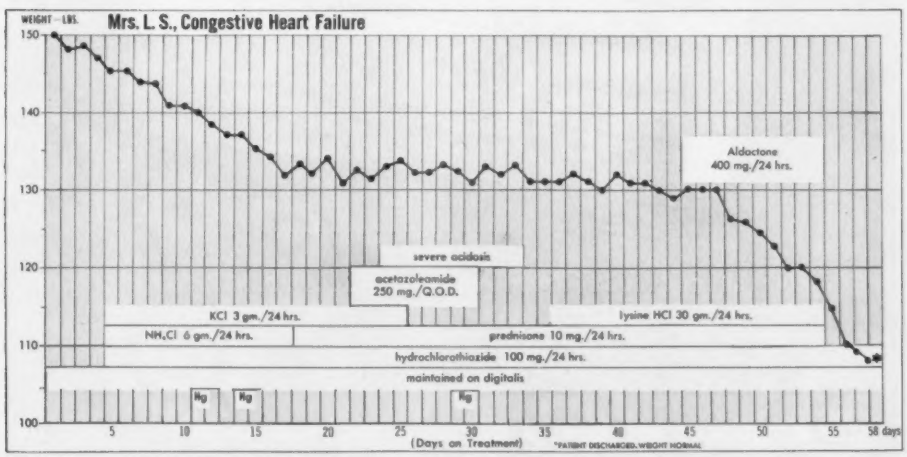
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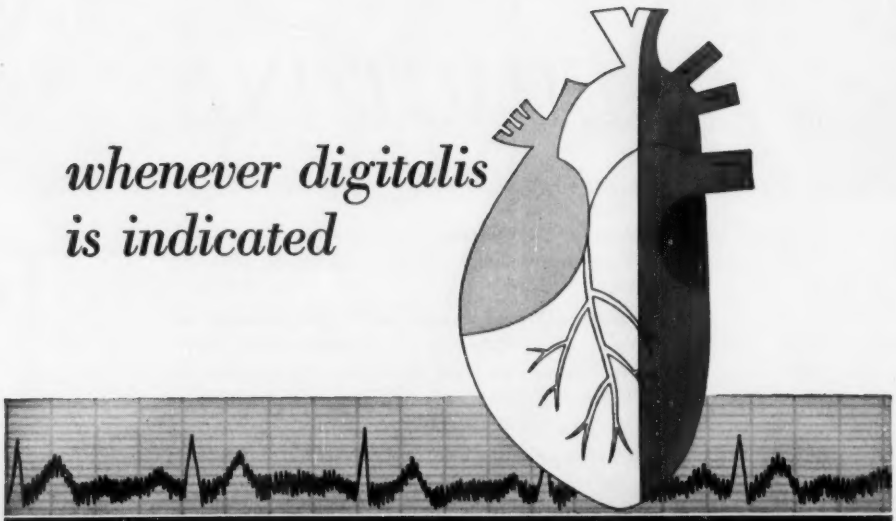
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Dates Set for Michigan Conference on Aging

The dates for Michigan's "Little White House Conference on Aging" have been set for September 21-22.

Wilma Donahue, of the University of Michigan Department on Gerontology, is General Chairman of the state-wide gathering of citizens interested in the problems of the senior citizens. The conference will take place in Lansing's Civic Center.

* * *

THE PUBLIC IS invited to the Lansing meeting, which will be divided into the following eight discussion sections:

1. Population, economic security and employment.
2. Health and medical care, and rehabilitation.
3. Education, free time and recreation.
4. Family, housing and group living.
5. Professional training and research.
6. State and community organization.
7. Religious leadership.
8. Voluntary agency and social services.

Participants will bring to the two-day meeting recommendations of the eleven regional meetings held in all parts of the state during March, April and May.

They also will formulate Michigan's report to the national White House Conference, scheduled for next January in Washington, D. C. MSMS members are urged to make plans early for attending this important meeting.

The Michigan Commission on Aging is responsible for the state-wide conference and the report to the national conference.

* * *

MANFRED LILLIEFORS, research analyst for the Michigan Department of Social Welfare, has been named director of Michigan's new Commission on Aging. Mr. Lilliefors brings to the Commission over 35 years' experience in public and private welfare agency work. Twelve years ago he directed a study of services for the elderly for the Ohio Citizens Council.

Since joining the Social Welfare Department in 1951, Mr. Lilliefors has participated in numerous community and state aging projects. He was chairman of one of two Lansing committees which stimulated the formation of that city's burgeoning Project on Aging.

Created by the 1960 Legislature, the Commission became active on July 1.



ANCILLARY 1269

Says Americans Want Action on Aging

Americans are anxious for action on aging, James Watt, M.D., special assistant on aging to the Secretary of Health, Education and Welfare, declared in a keynote speech at the University of Michigan's 13th annual Conference on Aging.

"If the proper people do not take the proper action soon on some

of our aging problems then improvised and unsound measures will be taken," Doctor Watt said.

The 1961 White House Conference on Aging pre-conference planning has stimulated formation of numerous state and local committees on aging, Doctor Watt declared.

* * *

ANOTHER CONFERENCE SPEAKER said the gradual withdrawal from worldly concerns is a major characteristic of aging in America. This finding was reported by Elaine Cumming, of the New York State Department of Mental Hygiene. She based her conclusion on intensive analysis of 275 adults over 50 in Kansas City, Missouri.

"The aging individual comes to think of time as a scarce commodity rather than as something which stretches forward indefinitely. He re-orients himself to its scarceness by creating new priorities for its use and by giving up certain aspirations he may have had."

Conference participants heard Ernest W. Burgess, of the University of Chicago, Industrial Relations Center, indicate that the preference of older people for familiar friends and social surroundings probably stems from changes in patterns of family living.

* * *

COMPANY-SPONSORED HEALTH programs can help family physicians render better service to their patients, a Cornell University researcher told the conference. Professor Fred Slavik said, "Well thought-out extensions of industrial medicine programs would increase the scope of the family physician's work and result in improved use of his time."

Lawrence Boucher, retirement counselor for Allis-Chalmers Manufacturing Company, Milwaukee, Wisconsin, explained that there are several reasons why industry should work for the welfare of older employees. Among them: improved physical and mental health of workers, improved loyalty to organization, increased production, better public and employee relations, and giving positive assurance to workers that their company is interested in developing satisfied groups of retirees.

WSU to Shift Its Medical School To New Medical Center

An addition to Detroit's proposed 100 million dollar Medical Center was decided on by the Wayne State University Board of Governors in June when it approved moving the College of Medicine into the new Medical Center surrounding Harper, Grace, Woman's and Children's Hospitals.

President C. B. Hilberry said a new Medical Sciences Building would probably be built in the vicinity of St. Antoine and Alexandrine, about a mile and a half from the Wayne campus. The present medical science building is four miles from the main campus.

Funds will be sought from the State Legislature and the Federal government.

The present building, built in 1953, will probably be converted to a neuro-psychiatric research center because of its proximity to Lafayette Clinic.

Offer Conference Digest

A complete report of the 1959 National Conference on Homemaker Services, which was co-sponsored by the AMA and other organizations and federal agencies, is available from the United States Government Printing Office. The publication ($1.25) is entitled "Public Health Service Publication No. 746." The report tells the story of the conference which was designed to stimulate the development of homemaker services throughout the United States.

Allergy Society Elects

The Michigan Allergy Society has elected officers for 1960-61. Robert G. Lovell, M.D., Ann Arbor, is the president, assisted by Alex S. Friedlander, M.D., Detroit, vice-president; Hilda M. Hensel, M.D., Monroe, secretary, and Israel Wiener, M.D., Detroit, treasurer.

1960 Winners Chosen for Fredrick A. Coller Award

The Ninth Annual Competition for the Frederick A. Coller Award, sponsored by the Regional Committees on Trauma and Nutrition and the Michigan State Chapter of the American College of Surgeons, was held in Ann Arbor, before 200 members of the American College of Surgeons and their guests.

A total of 20 10-minute papers were given by surgical residents in varying stages of training presenting clinical and experimental researches in problems related to the surgical management of trauma and attendant nutritional problems.

First prize, consisting of the Frederick A. Coller Scroll awarded to both the participant and his hospital and a monetary award of $100, was won by John Mitchell, M.D., Wayne County General Hospital, Eloise, who was sponsored by Drs. Robert Tygart and Wayne Glas. The title of the winning paper was, "A Clinical and Experimental Study of Pulmonary Contusion."

Second prize, a monetary award of $50, was won by Robert Shanahan, M.D., of St. Joseph Mercy Hospi-

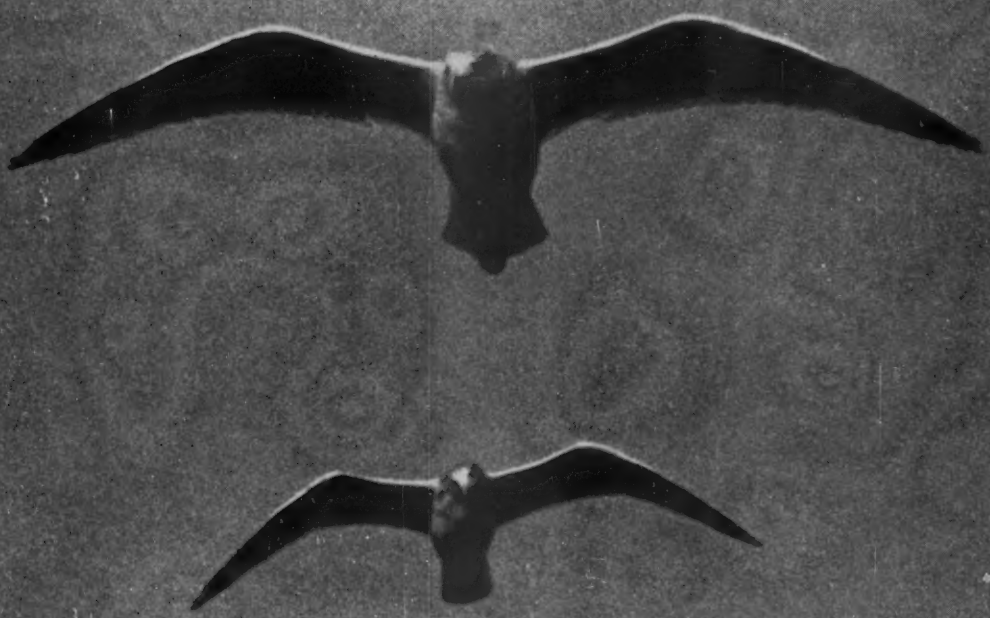
(Continued on Page 1272)

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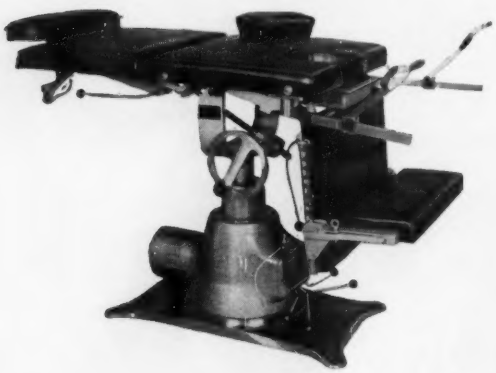
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(Continued from Page 1270)

tal, Ann Arbor. He was sponsored by Dr. Rigdon Ratliff. The title of his paper was, "Chemical Dysentery (Phisohex)".

Third prize, a monetary award of $25, was won by Charles Friend, M.D., of the Wayne County General Hospital. The title of this presentation was, "Studies on Urinary Extravasation." He was sponsored by Drs. Jack Lapides and Wayne Glas.

Following the afternoon scientific session, dinner was served at the Barton Hills Country Club. The awards were then presented, after which Owen H. Wangensteen, M.D., President of the American College of Surgeons, spoke on, "The Education of a Surgeon."

Doctor Wangensteen was also chairman of the committee of judges for the awards. The other judges were: G. Clare Bishop, M.D., Almont; Edwin G. Bovill, M.D., Detroit; Reed M. Nesbit, M.D., Ann Arbor; and William L. Sherman, M.D., Detroit.

Human Cell Bank

Establishment of a "cell bank" to be used for research on cancer, viruses and in general biology, has been announced by Wayne State University College of Medicine and the Child Research Center of Michigan.

The bank, one of three in the United States, will be directed by Dr. Cyril S. Stulberg, associate professor of microbiology and Lawrence Berman, M.D., professor and acting chairman of the Department of Pathology, WSU College of Medicine. Storage of living human and animal cells will be preserved by refrigeration at a temperature of 100 degrees below zero Fahrenheit.

The foramtion of the three cell banks is the result of a new program initiated by the Viruses and Cancer Advisory Panel of the National Cancer Institute.

Receives Cancer Charter

The American Cancer Society national board of directors at the annual meeting at Los Angeles, June 3, issued a charter to the Southeastern Michigan Committee, Inc. Under the terms of the charter, the Committee is required to change its corporate name to "American Cancer Society Southeastern Michigan Division, Inc."

Leads Medical Group

James H. Beaton, M.D., Grand Rapids, has the unique opportunity to serve as president of the Michigan Society of Obstetricians and Gynecologists for the second time. He was president in 1958 and has been elected again to the post for 1960-61. He succeeds G. Paul Hodgkinson, Detroit, president of the American College of Obstetricians and Gynecologists.

Say you saw it in the Journal of the Michigan State Medical Society

Asks States to Advise On Elderly Care

The National Advisory Committee of the White House Conference on Aging is asking all fifty state conferences to make recommendations on how much the Federal Government should do to help the states care for elder citizens.

The White House Conference will meet January 9-12, 1961.

A forty-two-page pamphlet, prepared by former Representative Harry G. Haskall, Republican of Delaware—chairman of the White House conference's planning committee on Federal organization and programs, has just gone out to the states.

Mr. Haskall has analyzed the problems for the future. In the pamphlet, he says:

"It may be pointed out that the legislation setting up the White House Conference on Aging would not have been passed were there not some disposition on the part of members of the Congress, and particularly committee members dealing with legislative proposals in the field to explore further the question of Federal responsibility."

"What are the wishes of the states themselves?" the pamphlet asks. "Do they want Federal grants-in-aid specifically keyed to the aging, and are they prepared to provide matching funds should these be required? If so, through what channels would the states then prefer to receive the Federal grants?"

Urge Youths Enter Mental Health Careers

An attempt to alleviate the manpower shortage in the nation's mental hospitals and clinics by interesting teen-agers in entering careers in the mental health field has been launched by the National Association for Mental Health.

The Association's more than 800 affiliates and 1,000,000 members will participate in a Careers Program to inform teen-agers about job opportunities and requirements in this area. The youths will be contacted directly through schools, clubs, civic organizations, and by school guidance counselors, principals, and teachers.

Decline in Infant Deaths Seen Leveling Off

The steady progress in reducing infant mortality has been leveling off in recent years, and any new significant declines must await breakthroughs in research on leading causes of death, an official of the National Office of Vital Statistics said.

From 1933 to 1949 the infant mortality rate declined by an average of 4.3 per cent a year, but since 1950 the rate has fallen by an annual average of only 2 per cent, reported Iwao M. Moriyama, Ph.D., chief of the mortality analysis of NOVS.



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Infant mortality reached an all-time low of 26 per 1,000 live births in 1956. Since then, the rate has been rising in some states and declining more slowly in others. The estimated rate for the nation last year was 26.4.

The basic problem of the infant death rate remains to be solved, Moriyama said. The death rate for congenital malformations and such diseases of early infancy as birth injuries, asphyxia of the newborn, and prematurity has remained fairly high for many years, he pointed out.

American Trudeau Society Selects New Name

The medical section of the National Tuberculosis Association has changed its name from the American Trudeau Society to the American Thoracic Society. The new name was chosen to reflect more accurately the broad interest of the membership in all diseases of the chest and respiratory tract, as well as tuberculosis.

Organized in 1905 as the American Sanatorium Association, the ATS was reorganized in 1939 as the medical section of the NTA and named in honor of Dr. Trudeau, who established the famous sanatorium that bore his name at Saranac Lake, N. Y. The Society has a membership of more than 5,000 physicians and other scientists in North America and throughout the world.

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the most potent theophylline elixir available... may avoid need for I.V. injection

1. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 2. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) equivalent to 0.16 Gm. (2½ gr.) Theophylline U.S.P. Supplied: Bottles of 1 pint and 1 gallon.

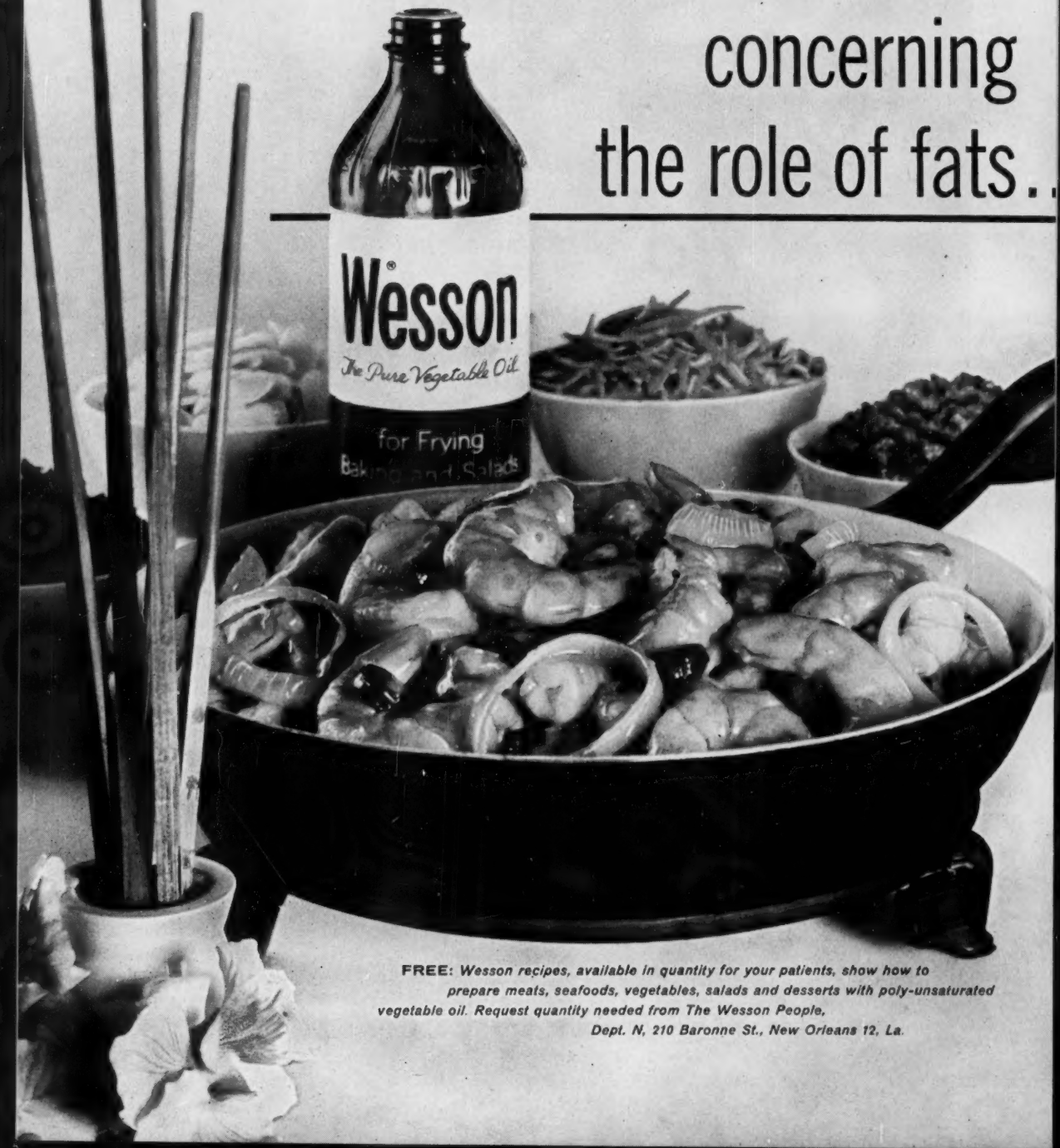
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Dietary Linoleic Acid and Linoleate—*Effects in Diabetic and Nondiabetic Subjects with and without Vascular Disease*

A paper by Laurance W. Kinsell, M.D., et al., excerpted from Diabetes—The Journal of the American Diabetes Association, May-June 1959

"*Linoleic acid as the major 'hypocholesterolemic agent' in vegetable fats.* The question has been raised as to the mechanism of lowering of the plasma lipids by a variety of vegetable fats. Among the entities present in or absent from vegetable fat which have been considered are: (a) the absence of cholesterol; (b) the presence of certain vegetable sterols; (c) the presence of certain vegetable phospholipids; (d) the nature of one or more of the fatty acids present; (e) the presence of trace materials.

.in the diet

The absence of cholesterol has been excluded as a major factor.[5a] Phospholipids, if they contain a sufficient quantity of unsaturated fatty acids may produce a striking reduction. In our experience thus far saturated phospholipids fail to produce such an effect.[7]

Beveridge and his associates believe that vegetable sterols, particularly beta-sitosterol, are responsible to a significant degree for the cholesterol-lowering effect.[8] In our experience the vegetable sterols have a relatively weak and unpredictable effect of this sort.

Since the fatty acids of animal fats are predominantly saturated, and the fatty acids of most vegetable fats are predominantly polyunsaturated, with linoleic acid as the major component of the vegetable fats which lower cholesterol and other lipids, the question arises whether linoleic acid per se is capable of lowering plasma lipids. As reported previously[7] this is indeed the case. In a recent study in a young male with peripheral atherosclerosis in association with elevation of plasma cholesterol and of total lipids, ethyl linoleate produced a greater fall in the plasma lipid levels than had moderate amounts of natural sources of unsaturated fat. Linoleic acid, therefore, appears to be the most important single lipid-lowering component of vegetable fat.

* * *

Significantly higher levels of cholesterol were observed during oleate administration than during administration of equal amounts of linoleate. The relatively low cholesterol values during the second oleate period may have been related to linoleate stored in fat depots. The fatty acid composition of the cholesterol esters reflected the fat which was fed, i.e., the mono-enoic† acid content averaged more than 40 per cent during oleate feeding and less than 20 per cent during linoleate ingestion. Essentially, a mirror image of this resulted during linoleate feeding, at which time di-enoic acid predominated.

* * *

The data presented in this paper appear to establish that linoleic acid administered either as purified ethyl ester or as naturally occurring fat, in sufficient quantity, in properly constructed diets, will reduce plasma lipids to normal levels. The amount of linoleic acid required appears to bear a direct relationship to the amount of saturated fat included in the diet. Linoleic acid requirement may also bear a significant relationship to the amount of atherosclerosis present.

The transition from evaluation of the effect of dietary entities upon plasma lipids, to the evaluation of the effect of such materials upon vascular disease is difficult. However, such evaluation is not impossible. The requisites are adequate measuring sticks and well-controlled studies of sufficient duration. The duration of observation of effects of unsaturated fat in diabetic and nondiabetic patients with vascular disease is in no instance more than five years, and in the majority of instances, less than three. Our present impression is that improvement has occurred in some patients with atherosclerosis and with diabetic retinal and renal disease which was more than we would have anticipated in terms of the natural course of the disease. However, since it is well known that major fluctuations in these diseases can occur in individuals receiving no treatment, we believe it is appropriate at this time to say that no untoward effects appear to result when one prescribes diets containing large amounts of unsaturated fat for patients with such diseases, and it is not impossible that beneficial effects may be associated with such diets."

* * *

5a Kinsell, L.W., Partridge, J. W., Boling, L., Margen, S., and Michaels, G.D.: Dietary modification of serum cholesterol and phospholipid levels. J. Clin. Endocrinol and Met. 12:909, 1952.

7 Kinsell, L. W., Friskey, R., Splitter, S., Michaels, G. D.: Essential fatty acids, lipid metabolism, and atherosclerosis. Lancet 1:334, 1958.

8 Beveridge, J.M., Connell, W.F., Firstbrook, J. B., Mayer, G.A., and Wolfe, M.J.: Effects of certain vegetable and animal fats on plasma lipids of humans. J. Nutrition 56:311, 1955.

† Mono-enoic (mono-unsaturated) acid is presumably synonymous under these conditions with oleic acid and di-enoic (di-unsaturated) acid with linoleic acid

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

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Wesson is 100% cottonseed oil . . . winterized and of selected quality		Palmitic, stearic and myristic glycerides (saturated)	25-30%
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Total unsaturated	70-75%	Never hydrogenated—completely salt free	

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Progressive Report on Nursing Homes

In July, 1957, the Michigan Department of Health was given responsibility for licensing of nursing homes in the state. At that time the department adopted a progressive improvement plan which required that nursing homes meet a progressively larger number of regulations each year. The rules provided for provisional licenses for a period of 36 months and full licenses at least by the end of that time. In 1957, there were 600 homes with about 13,500 beds. About 70 per cent of these homes had full licenses. In 1958 and 1959 the department demanded immediate compliance with 136 of the 152 rules which had been established by the department. In 1960, immediate compliance was required for 200 of the 252 rules.

Our records show that since September of 1957, 104 nursing homes have closed, 72 new homes have opened. This represents a net loss of 32 homes but, at the same time, there has been a net gain of 2,700 beds. This means that today we have more larger nursing homes better equipped to care for their residents and we have eliminated a number of the smaller, poorly equipped and poorly managed homes.

Next year, immediate compliance will be required for nine more rules, leaving only 43 of the 252 rules. At the present time the department is aiming for immediate compliance with all the rules by January 1 of 1962, about five years after the beginning of the new licensing program.

Addition to Staff of Division of Maternal and Child Health

On June 1, 1960, Eugene Crawley, M.D., filled a vacancy of long standing as pediatric consultant and chief of the Child Health Section, Division of Maternal and Child Health. Doctor Crawley is a board certified pediatrician who has been in private practice in Little Rock, Arkansas, for the past eleven years. He is a member of the Committee on the Fetus and Newborn of the American Academy of Pediatrics. Prior to coming to Michigan, he served as chairman of the Committee on the Fetus and Newborn of the Arkansas branch of the American Academy of Pediatrics, chairman of the Arkansas State Medical Society's Committee on School Health and Physical Fitness, a member of the Joint Committee on School Health of the Arkansas State Departments of Education and Health, chairman of the School Health Committee of the Pulaski County Medical Society, and chairman of the Infection Committee for both local hospitals in Little Rock.

Doctor Crawley's services as a consultant in child health are available to local health departments, physicians, and hospitals.

Laboratories to Discontinue Colloidal Gold Tests on Spinal Fluid Specimens

On July 1, 1960, the Division of Laboratories discontinued the performance of colloidal gold tests on spinal fluid specimens.

The development of reliable quantitative methods for the determination of total proteins in spinal fluids has decreased the clinical value of colloidal gold tests. Experience has shown that this procedure is not a reliable means of differentiation of the various types of central nervous system syphilis.

Antibiotic Hunt

Of 9,960 samples of antibiotic substances submitted to the National Cancer Institute, Public Health Service, for screening against cancer cells, 66 have shown marked anticancer activity, and four are now being developed for more advanced investigations.

Vigorous Effort in Hospital Survey and Construction

Reorganization—Plans are underway to move the Section of Hospital Survey and Construction of the Division of Hospital and Medical Facilities to the Michigan Department of Health building on DeWitt Road. The transfer will take place as soon as the space assigned to the Section of Hospital Survey and Construction can be made available.

Summary of Active Projects

	5/60	5/59
In Planning	15	12
Under Construction	17	34
Opened to Use	19	9
Total	51	55

The large number of projects opened to use reflects the completion of projects placed under construction during the anti-recession program of 1958-59.

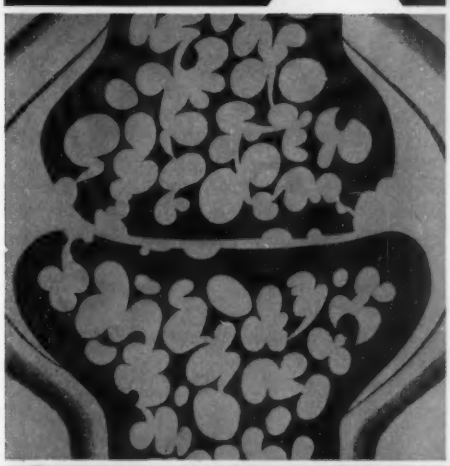
in rheumatic disorders

whenever aspirin proves inadequate

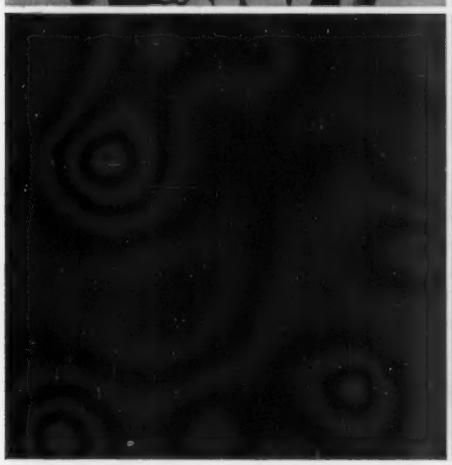


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Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
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Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.



Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

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165-60

Pathology Comment

These items are provided by the Michigan Pathological Society

Granulomata

The importance of a systematic approach to the diagnosis of granulomata was emphasized recently by Lyle A. Weed, M.D., Professor of Bacteriology in the University of Minnesota Graduate School. Speaking at the postgraduate medical study course presented by the University of Kansas School of Medicine, Dr. Weed pointed out that granulomata may result from contact of the tissues with a great variety of chemical, physical and microbiologic agents (talc, oils, silica, beryllium, Brucella, fungi, and acid-fast bacteria being the more common ones).

Curettings May be Needed

One must keep in mind that micro-organisms may be few in number and they may not be uniformly distributed throughout the lesions. It is desirable, therefore, to make massive inoculations; to assure this the Pathology Department must be provided with adequate unfixed material. Curettings may be necessary to supplement swabbed specimens.

Fluorescent Antibody Method

Histologic examination many times will give a clue to the etiology, particularly if special stains are used, but such an examination cannot be relied upon to determine the nature of the organism. The morphologic similarity of Cryptococcus, Blastomyces, Histoplasma, and even Coccidioides is frequently very striking. The acid-fast bacilli of M. tuberculosis, M. balnei, M. ulcerans or saprophytes cannot be differentiated in histologic sections by the present techniques. Fluorescent antibody methods may, in the future, become reliable for diagnostic purposes. Carefully controlled studies on a large number of patients will be necessary to determine this.

Search for Microbiologic Agents

The etiologies of certain granulomata remain unknown; e.g., sarcoid, cat scratch fever, eosinophilic granuloma, histiocytosis or the granulomatous form of Hodgkin's disease. However, these should always be studied for microbiologic agents, especially acid-fast bacilli. Brucella and fungi are sometimes present in lesions with these histologic diagnoses. A lesion histologically diagnosed as sarcoid takes on a new meaning when it is found to contain tubercle bacilli. Dr. Weed believes skin tests and other serologic procedures are of more importance for their prognostic value or as epidemiologic tools than in the accurate diagnosis of an infection.

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Far too many tip inward—suggesting the need for medial supportive devices such as the long counter extension, heel wedge, angled or even Thomas Heel, re-inforced shank, arch pads.

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One glass, or ½ pint, of plain Buttermilk (uncreamed) contains only 87 calories; a whole quart, only 350. Yet uncreamed buttermilk contains all of whole milk's complete proteins, B vitamins, and minerals. One good dietary reason!

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Making buttermilk sounds simple, but certainly isn't simple at all! Borden's Buttermilk has a deserved reputation for fresh, sweet wholesome flavor.

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EDITORIAL COMMENT

Watch Out!

Virginia Medical Monthly, April, 1960

It is quite possible the powers that be in Washington have more than one reason for complaining about the prices of drugs. Senator Estes Kefauver's drug price investigating subcommittee would have us believe that the government's sole interest is "simply with the price of drugs—a price which must be paid by someone under any system of medical care." I think there is a psychological reason which they hope to keep under cover. This Senate antitrust investigation is just another cunning approach in the attempt to slip socialized medicine in at the back door. It appears to me that Mr. Kefauver almost gave this fact away in his opening statement when he said: "It is not the purpose of these hearings to question in any way the American system of private medical practice." I react to this statement in the same manner I would if a small boy should rush into my office and exclaim: "Doctor, someone batted a baseball through your back window—and I don't want you to think that I did it."

If these investigators' thoughts were just in the drug field, they should also be concerned about quality as well as price. They certainly have shown a lack of interest in the cost of pharmaceutical research and manufacturing, and without research drugs would soon degrade in both quality and quantity. The Senator's line of reasoning in advocating that druggists be allowed to use generic instead of brand names, would throw the drug business into a tail spin within a short time. If one company spends a million dollars to produce a new drug, and another concern is allowed to copy the formula, pay none of the research cost, and market the product at a low price, the results would be disastrous. The better firms would go broke, initiative to find new drugs would be smothered and we would find ourselves advancing in reverse—back towards the "calomel and castor oil days."

I feel that these governmental probes are motivated, primarily, for publicity. If they can attract enough attention by their investigations of the major drug manufacturing firms, and lead the American people into believing that the prices of drugs are too high, it might be possible to gain a large number of sympathetic listeners.

They hope to stir up enough interest in the drug controversy to swing the spotlight away from the doctors for a while, give us a breathing spell, make us feel complacent and lessen our vigil against legislation like the Forand bill. It is their wish that we don't get wise to their twofold purpose of these investigations in relation to the Forand bill itself. First, they will attempt to convince the lay public that older people, on social security, will not be able to pay the high drug prices—and that the government should step in to help. Second, if these tactics could get a Forand type of legislation passed without enough medical publicity to stir up strong opposition—they would be in position to widen social security to cover everybody. Then we would have socialized medicine under another name.

People, consciously, or unconsciously, associate drugs and physicians together. An aroused populace against drug prices would not be too friendly towards the medical profession. Such a situation would gain recruits for a more effective battle against the free practice of medicine. While we sit on the side lines, apparently unmolested, and watch the steam roller attempt to crush the drug firms, we must remain alert. We could get caught napping as Hitler did one time during World War II.

AMA Statesmanship

The New York Times, May 29, 1960

The American Medical Association deserves credit for its statesmanship in staging its conference in Chicago on health insurance plans. Few current national issues are more important, and to more people, than protection from the economic hazards of illness, and few have been more bedeviled by bitter controversy—to which the AMA has contributed its share in the past. But at Chicago a supreme, and successful, effort was made to get all those involved in health insurance to an even keel, with mutual understanding as to the course to steer by.

By invitation of the AMA—and for the first time in history—leaders of organized medicine, labor, industry, voluntary health insurance plans and the insurance companies spent two days in a remarkably amicable discussion of how protection is now being given and how those that give it could do a better job. Opposing economic theories and present political issues were, by common consent, ruled out and, except for outside speakers, with good effect. And the widely held conviction that, if privately provided protection fails to meet the public need and demand, the Gov-

(Continued on Page 1284)



Cartoon idea by pharmacist Emil Magdalener

Many of you may have seen a recent cartoon depicting a midnight scene in front of a pharmacy. A woman is pounding on the door and the pharmacist is leaning out the window of his apartment over the store. "Open up," shouts the woman. "My husband is sick and I need a stamp so I can send this prescription to the mail order house."

The drug that always fails is the drug that isn't there

Far-fetched? Perhaps, but there are those who would have us believe that our present system of drug distribution is inefficient and costly, and should be replaced by presumably more efficient and cheaper centralized or bureaucratic methods. Disregarding the probable political philosophy behind these suggestions, consider what a marvelously intricate and efficient system of drug distribution we have in this country. • From the laboratories of the manufacturers comes a steady stream of new and better drugs for your patients. Warehoused and stocked by drug wholesalers, these products are available in over 53,000 pharmacies scattered across the length and breadth of our land. And woe to the pharmacist who hasn't been provided with yesterday's laboratory discovery for your use in treating a patient today. • The economists speak of "utility of time" and "utility of place." We simply say that you can confidently prescribe *what* you choose, *when* it is needed, *wherever* your patient may be.

This message is brought to you by the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

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AMA Statesmanship

(Continued from Page 1282)

ernment would take over gave the meetings a sense of urgency.

The whole affair was an impressive demonstration that the medical profession has come to realize that, apart from therapy itself, doctors should not have a monopoly in the field of medical care. There was a welcome professional interest in, and tolerance of, diversity and experiment in the administration and economics of medical care—and a recognition of the part which its consumers can and should take in these new directions. There should be more such meetings and it is good news that the AMA's Council on Medical Service will recommend a program for them to the association's convention at Miami Beach next month.

The Family Doctor Holds His Own

Marshall Evening Chronicle, November 18, 1959

The family doctor holds a high and honorable place in American history and tradition. The very phrase brings up pictures of a dedicated physician, fighting his way through storm and darkness in a horse and buggy or a primitive car.

Yet, some years ago there was a feeling that the family doctor was on the way out, and that medical knowledge had become so vast and treatment so complex that only specialists could meet the need. And, for a time, the statistics bore this idea out. In 1940, only one medical student in 10 planned on entering general practice. But a dramatic change has taken place. Today, more students are going into general practice.

There are good reasons for this. The general practitioner of today is far more competent, far more knowledgable, than his predecessors. Post-graduate work, reading, medical meetings and other factors see to it that he keeps up with medical progress. And there is more to the matter than just the question of competence. The family doctor fills a niche that no one else can fill. He knows his patients—and they know him, as a friend as well as a medical man. He is on call when needed. He brings with him confidence and peace of mind—psychological medicines, so to speak, which are important to building and regaining health. He knows when a specialist should be summoned, and what kind.

The American scene wouldn't be the same without the family doctor. It's good to know that he is holding his important place in the great canvas of American medicine.

Selected for Who's Who

Archer A. Claytor, M.D., of Saginaw, has been selected for listing in the next edition of "Who's Who in America." Doctor Claytor was named "Michigan's Foremost Family Physician" by MSMS in 1959. Since 1958, he has served on the Virgin Islands Corporation by appointment from President Eisenhower. He has practiced in Saginaw since 1936.

* * *

MEDICAL TELEVISION SHOWS—The Michigan Health Council reports that the following topics were covered in June on the weekly Sunday morning program over WJBK-TV in Detroit: A Career in Bacteriology, Summer Camp for Diabetics, Health Department Approved Vacation Sites and Atoms for Health.

* * *

POPULAR ATTRACTION—"Healthland," illustrating the dramatic contrast between techniques and materials of health care available 100 years ago and those available today, has proven popular at Freedomland, U.S.A.

Freedomland is the new amusement park located in New York City which is designed and constructed in the outline of the United States and recreates many of the major stories in the development of American history.

Healthland consists of an authentically furnished mid-nineteenth century apothecary shop, a display of Schering's modern pharmaceutical research and production facilities, and an exhibit explaining the requirements and opportunities of various careers in the health fields.

The health exhibition is sponsored by Schering Corporation. AMA helped to prepare the project.

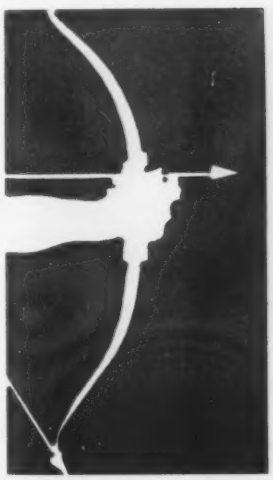
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NURSING FELLOWSHIPS—The National League for Nursing announces continuation of the National League for Nursing Fellowship Program, made possible by a grant from the Commonwealth Fund. The program has been in existence since Spring, 1955, and a total of 147 fellowships have been awarded—117 to candidates for the doctor's degree and 30 to candidates for the master's degree.

The purpose of the NLN Fellowship Program is to provide funds to subsidize programs of advanced study for nurses of proven ability who show promise of making a highly distinctive contribution to nursing.

Application for fellowships must be made in writing to the National League for Nursing, Inc., 10 Columbus Circle, New York 19, New York.

Contributions for this "News Briefs" department are invited from individual physicians, from county societies, and from other health organizations. Please direct your contributions to the Editor.



WIN SKF FELLOWSHIPS—Two Michigan medical students are among 28 who have received fellowships from Smith, Kline & French Laboratories to visit remote parts of the world to study "grass roots" medicine.

The Michigan students are John C. Rienstra, of Grand Rapids, senior at Wayne State University College of Medicine, who gets $1,620 to spend 12 weeks at the Sudan United Mission in Nigeria, and Arnold Schuring, also of Grand Rapids, senior medical student at the University of Michigan. He will receive $2,441 so he and his wife, a registered nurse, can spend 11 weeks at Takum Christian Hospital, Nigeria.

* * *

TO SPEAK IN WEST—Several Michigan doctors of medicine will speak at the American College of Surgeons Clinical Congress October 10-14 at San Francisco. They include T. N. Evans, M.D., Ann Arbor; C. Paul Hodgkinson, M.D., Detroit; Charles S. Stevenson, M.D., Detroit; Harry M. Nelson, M.D., Detroit; Robert C. Bassett, M.D., Lansing; Richard C. Schneider, M.D., Ann Arbor; Alfred M. Large, M.D., Detroit; and Clifford D. Benson, M.D., Detroit.

* * *

HONORED BY MSU—Ruth Kraft Strohschein, M.D., Birmingham, received a Distinguished Alumni Award at the Michigan State University June commencement program. Doctor Strohschein, chief of pediatrics at Grace Hospital in Detroit, was graduated from Michigan State in 1927. Later she was the first woman granted a Ph.D. degree in medical physiology at Ohio State University and was the first woman doctor in Michigan chosen for selective service.

* * *

HONORED—Herbert H. Gardner, Detroit banker who is treasurer of the Michigan Foundation for Medical and Health Education, recently received a University of Michigan honorary alumnus certificate from Dr. Harland Hatcher, U-M president. Mr. Gardner is the 29th recipient of the honorary alumnus status since the school's Regents established this method of honoring distinguished citizens and friends of the university in 1931.

* * *

ATTENDS DENMARK MEETING—Thomas Francis, Jr., M.D., Ann Arbor, participated in the International Poliomyelitis Congress in Copenhagen, Denmark, in July.

* * *

PROJECT HOPE—"Project Hope," a plan that will send four modern hospital ships to ports-of-call around the world, was formally endorsed at Miami Beach by the American Academy of General Practice. The AAGP Board of Directors made a $1,000 contribution. The Academy further urged its 26,000 members to volunteer for either one-year or two-month tours of duty on one of the four newly equipped ships.

* * *

POLIO IMMUNIZATION—American and Russian scientists met recently in Moscow on the Sabin oral polio vaccine. The scientists presented voluminous scientific data concerning manufacture, safety for the vaccinated, spread to the unvaccinated, possible reversion to virulence, effectiveness and administration of the Sabin live-virus vaccine.

The vaccine, originally developed by Albert B. Sabin, M.D., of the University of Cincinnati, with more than $1 million in grants from The National Foundation, was given to 15 million Soviet citizens last year. It has now been fed to more than 60 million there and is currently being manufactured in the U.S.S.R. at the rate of several million doses a

adult stable diabetics and a significant number of sulfonylurea failures respond to

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adult stable diabetes

"In our experience the action of DBI on the adult stable type of diabetes is impressive . . . **88% were well controlled by DBI.**"[1]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI], and such control was occasionally superior to that of insulin. This was true regardless of age, duration of diabetes, or response to tolbutamide."[2]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

sulfonylurea failures

Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

"DBI is capable of restoring control in a considerable portion of patients in whom sulfonylurea compounds have failed, either primarily or secondarily."[5]

"All twelve secondary tolbutamide failures have done well on DBI."[6]

"34 out of 59 sulfonylurea primary failures were successfully treated with DBI."[7]



week. In Russia, the Sabine vaccine has officially been accepted for use in an all-out immunization program.

* * *

JOINS ABBOTT—Harold D. Kautz, M.D., secretary of the Council on Drugs of the American Medical Association, has taken a position as director of the division of product information in the Medical Department of Abbott Laboratories, North Chicago, Illinois.

Doctor Kautz, who has been connected with the AMA in various capacities for 21 years, was guest speaker at the 1960 Michigan Clinical Institute.

* * *

SEEK ESSAYS—The American Urological Association offers an annual award of $1000 for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than 10 years, and to hospital interns and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, California, May 22-25, 1961.

For particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland.

* * *

1964 CLASS AT UM—The University of Michigan Medical School has accepted 194 students to enter in September as the Class of 1964. An additional 26 students have been chosen as alternates, to fill vacancies created by drop-out, and to bring the total entering class to 200. Twenty of those accepted are women, twice the number accepted last year.

The University of Michigan has the largest entering class of any medical school in the nation. Nearly 800 students applied for the 200 places.

Eighty-five of the entering students took undergraduate work at the U-M. Other Michigan schools represented include: Wayne State University, 21; Albion College, 13; Michigan State University, 7; Hope College, 6; Western Michigan University, 6; Calvin College, 5. The Class of '64 also includes representatives from Hawaii, Germany and The West Indies.

* * *

FORTHCOMING BOOK—The book "Americans View Their Mental Health" was written by Gerald Gurin, Joseph Veroff, and Sheila Feld of The University of Michigan Survey Research Center. This book summarizes the first nationwide, family-by-family analysis of how Americans respond to the pressures of modern living. The study was conducted by the Survey Research Center for the Joint Commission on Mental Illness and Health under an authorization from the Congress of the U. S.

* * *

MEDICAL EDUCATION GRANT—A contribution of $15,000 to the National Fund for Medical Education was made recently by the Schering Foundation. Established and supported by Schering Corporation of Bloomfield, New Jersey, the Foundation is a nonprofit concern dedicated to philanthropic support of charitable, educational and scientific projects, primarily in the field of medicine and health.

Since 1952, NFME has given $22 million to medical schools.

* * *

HELPS SCHOOL HEALTH—A. J. May, M.D., Benton Harbor, was appointed as medical representative to the newly created Health Council of the Benton Harbor School System.



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1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

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RACKHAM RESEARCH GRANTS—Research grants totaling $112,519 have been awarded by the Horace H. Rackham School of Graduate Studies to 65 faculty members of the University of Michigan. Following is a list of faculty recipients and their general area of research:

Health Sciences: William W. Coon (surgery); Wilfrid T. Dempster (anatomy); Pearl L. Kendrick (epidemiology); Charles A. Sanislow (surgery); Park W. Willis (internal medicine); George D. Zuidema (surgery). Nancy O. Lurie (public health); and Norman W. Rieck (anatomy).

* * *

SEVENTY-FOURTH BLUE SHIELD PLAN—Surgical Service, Incorporated, a medical-surgical Plan serving the State of New Mexico with headquarters in Albuquerque, has been approved as an active member of the National Association of Blue Shield Plans. The New Mexico Plan has been in operation for 13 years and has enrolled more than 55,000 members in that period of time.

New Mexico Blue Shield brings to 74 the number of Blue Shield Plans and affiliates in the United States and Canada.

* * *

MORE CANCER GRANTS—The American Cancer Society has awarded $89,425 in three research grants for cancer studies at Wayne State University. These grants are part of the Society's current support of cancer research across the nation to a total of $17,500,000.

The Wayne studies are under the direction of James E. Lofstrom, M.D., Melvin Sikov, M.D., Arthur J. Vorwald, M.D., and T. T. Tchen.

* * *

PROFESSORS RETIRE—Two professors of internal medicine, Cyrus C. Sturgis, M.D., and Paul Barker, M.D., have retired from the University of Michigan after 33 and 35 years of service, respectively.

* * *

BEGIN NEW U-M PLAN—Thirty-two top-ranking men and women students of The University of Michigan Medical School were selected for a new special studies program this fall.

The hand-picked group of thirteen entering freshmen and nineteen sophomores will be in an extensive extra-curricular program, developed earlier this year as an incentive to superior students. The work is an addition to the basic requirements of the Medical School course.

* * *

NAMED TO HIGHER POST—John A. MacCartney, director of professional relations for Parke, Davis & Company since 1946, has been appointed director of public relations for the world-wide pharmaceutical firm. Mr. MacCartney succeeds Ralph G. Sickels, who will retire December 31 after forty years of service in public relations work with Parke-Davis.

Mr. MacCartney, a professional pharmacist, is a past president of the 30,000-member American Pharmaceutical Association.

Congratulations!

* * *

M.D. LOCATIONS—Through June 30, 1960

Assisted by Michigan Health Council—Albert C. Adams, M.D., Flint; Peter S. Thoms, M.D., Mt. Morris.

Placed by Michigan Health Council—Alvin J. Ratzlaff, M.D., Onsted.



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MEDICAL MEETINGS U.S.A.

SEPTEMBER

National Cancer Conference, American Cancer Society, Inc., and National Cancer Institute, September 13-15, Minneapolis, Minnesota. Ronald M. Grant, M.D., 521 West 57th Street, New York 19, Coordinator.

Ninth United States Civil Defense Council Conference, September 21-22, at the Leamington Hotel, Minneapolis, Minnesota.

College of American Pathologists, September 24-27, Palmer House, Chicago. Arthur H. Dearing, M.D., 2115 Prudential Plaza, Chicago, Executive Director.

Annual Otolaryngologic Assembly, September 24-30, University of Illinois College of Medicine Department of Otolaryngology, Chicago, Illinois. Write Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

American Society of Clinical Pathologists, September 24-October 2, Palmer House, Chicago. Claude E. Wells, 445 Lake Shore Drive, Chicago 11, Executive Secretary.

Eighth Congress of the Pan-Pacific Surgical Association, September 27-October 5, Honolulu, Hawaii. F. J. Pinkerton, M.D., Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

American Medical Writer's Association, November 18 and 19, Hotel Morrison. Harold Swanberg, M.D., 510 Maine Street, Quincy, Illinois, Secretary.

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OCTOBER

The American College of Surgeons 47th Annual Clinical Conference, October 2-6, Chicago.

Central Association of Obstetricians and Gynecologists, October 6-8, Kansas City, Missouri. Herman L. Gardner, M.D., 633 Hermann Professional Building, Houston 25, Texas, Secretary-Treasurer.

American Otorhinological Society for Plastic Surgery, October 9, Conrad Hilton Hotel, Chicago.

American Academy of Ophthalmology and Otolaryngology, October 9-14, Palmer House, Chicago. William L. Benedict, M.D., 15 Second Street, N.W., Rochester, Minnesota, Executive Secretary.

American Medical Association Industrial Health Conference, October 10-12, Hotel Charlotte, Charlotte, North Carolina.

Regional State Medical Journal Editors Conference, October 15-16, Phoenix Hotel, Lexington, Kentucky. J. P. Sanford, 1169 Eastern Parkway, Louisville 17, Managing Editor, Journal of Kentucky State Medical Association.

American Academy of Pediatrics, October 17-20, Palmer House, Chicago. E. H. Christopherson, M.D., 1801 Hinman Avenue, Evanston, Illinois, Executive Director.

National Safety Congress, October 17-21, Chicago. R. L. Forney, 425 North Michigan Avenue, Chicago 11, Secretary.

Postgraduate course in Laryngology and Bronchoesophagology, October 17-29, The Department of Otolaryngology, University of Illinois College of Medicine, Chicago, Illinois. Write Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Clinical Conference on Gynecologic Cancer, October 21 and 22, The University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, Texas.

American Heart Association, Inc., October 21-25, Jefferson Hotel, St. Louis. Rome A. Betts, 44 East 23rd Street, New York 10, Executive Director.

Mid-West Forum on Allergy, October 22-23, Penn-Sheraton Hotel, Pittsburgh. Macy I. Levine, 3347 Forbes Avenue, Pittsburgh 13, Program Chairman.

American College of Gastroenterology Annual Course in Postgraduate Gastroenterology, October 27-29, Bellevue-Stratford Hotel, Philadelphia, Pennsylvania. Write American College of Gastroenterology, 33 West 60th Street, New York 23, New York.

Clinical Orthopaedic Society, Inc., October, Milwaukee. Charles H. Frantz, M.D., 1810 Wealthy Avenue, S.E., Grand Rapids, Michigan, Secretary-Treasurer.

NOVEMBER

Thirteenth Annual Conference on Electrical Techniques in Medicine and Biology, October 31-November 1-2, Sheraton-Park Hotel, Washington, D. C.

American Medical Association Clinical Meeting, November 28-December 1, Washington, D. C.

DECEMBER

American Academy of Dermatology and Syphilology, December 3-8, Palmer House, Chicago. Robert R. Kierland, M.D., First National Bank Building, Rochester, Minnesota, Secretary-Treasurer.

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IN MEMORIAM

ELLIS H. STEFFENSEN, M.D., forty-eight, Detroit ophthalmologist, died April 9, 1960.

Doctor Steffensen, a native of Michigan, was graduated from the University of Michigan Medical School in 1940. He interned at Henry Ford Hospital in 1942-43. He was in military service from that time until 1946, when he returned to Henry Ford Hospital for his residency. He continued serving there as a staff physician, specializing in ophthalmology, until the time of his death.

SIDNEY BERMAN, M.D., forty-eight, retired Detroit physician, died April 20, 1960.

Born in New York City, Doctor Berman was a graduate of Wayne State University School of Medicine in 1938. He interned at Wayne County General Hospital and had his residency at Michael Reese Hospital in Chicago and Cedars of Lebanon in Los Angeles.

Doctor Berman returned to Detroit in 1954 to practice. He retired from practice in 1959 because of illness.

WILLIAM F. HAMILTON, M.D., eighty-four, a Detroit physician, died April 2, 1960.

Doctor Hamilton was graduated from Northwestern University Medical School in 1911. He returned to Detroit where he practiced his specialty, Ear, Nose and Throat. He was on the staff of Shurly Hospital.

He retired from practice in June of 1956.

GORDON B. MYERS, M.D., fifty-six, former professor and chairman of the department of medicine of the Wayne State University College of Medicine, died June 5, 1960.

A native of Detroit and a graduate of the University of Michigan Medical School, Doctor Myers served his internship and residency at Receiving Hospital. He served two additional years of medical residency at Peter Brent Brigham Hospital in Boston and did more work in Wurzburg, Germany.

He became the first full-time member of the Department of Medicine at WSU in 1934. In 1936 he became professor and chairman of the department and director of medicine at Receiving Hospital. Doctor Myers was also chief consultant in medicine at the Dearborn Veterans Hospital and the United States Public Health Service (Marine) Hospital at Windmill Pointe.

He dropped his administrative duties several years ago because of illness and retired a year ago.

He was a member of the Association of American Physicians, the American Society for Clinical Investigation, the Central Society for Clinical Research, the Detroit Academy of Medicine, Detroit Medical Club, Detroit Heart Club and Lochmoor Golf and Country Club.

JOHN RITSEMA, M.D., fifty-nine, Sebewaing physician and civic leader, died May 18, 1960.

Doctor Ritsema was graduated from the University of



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Michigan Medical School in 1925. He was chief of staff of the medical section of Bay City General hospital and on the staff of Mercy hospital in Bay City.

Doctor Ritsema was currently serving as president of the Huron County Medical Society.

In addition to his medical affiliations, he was past master of Wallace Lodge No. 434 F. & A. M., a member of Bay City Consistory, president of Sebewaing school board, past president of Sebewaing Rotary Club, served ten years as secretary of the Council of Administration of Sebewaing EUB church.

WILLIAM P. WOODWORTH, M.D., seventy-eight, medical director of the Red Cross in Detroit from 1951 to 1957, died May 22, 1960.

He was a former chief of staff at Providence Hospital.

Doctor Woodworth, noted in Detroit amateur music circles, was in demand as a cellist with various ensembles.

He was past president of the Bohemian Club and a Spanish-American War veteran.

COMMUNICATIONS

Milton A. Darling, M.D., President
Michigan State Medical Society
Dear Doctor Darling:

Thank you for your letter in which you informed me that I have become an active member of the Michigan State Medical Society.

I consider that being a member in the Michigan State Medical Society is a distinct honor and wish to express my sincere thanks to you and the entire Society for accepting me.

I am looking forward to being an active and useful member of this great Association.

Yours very truly,
F. E. FOURNIER, M.D.

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. . . that about 65 per cent of the 4.3 million babies born in the U. S. last year had part of their initial medical expenses paid by health insurance, and that total maternity benefit payments were estimated at $527 million.

. . . that an estimated 46 million children in the U. S. now are protected against the costs of ill health by health insurance.

. . . that in 1959 the American public received an average of $8 million a day in health insurance benefits from insurance companies alone.

Michigan Authors

Richard C. Schneider, M.D., Ann Arbor, "Chronic Neurological Sequelae of Acute Trauma to the Spine and Spinal Cord," *Journal of Bone and Joint Surgery*, March, 1960.

Rosser L. Mainwaring, M.D., Detroit, "Hemoglobin Levels and Blood Transfusions," condensed from J.M.S.M.S. in *Current Medical Digest*, June, 1960.

Morris J. Mintz, M.D., Detroit, "Contamination of Fluorescein and Furacin Eye Solutions," *Eye, Ear, Nose and Throat Monthly*, May, 1960.

Donald R. Kahn, M.D., Ann Arbor, and **Allan J. Munitz, A.B.,** Maryland, "Observations on an Effect of Beta sitosterol on 'Stypven Clotting Time,'" *University of Michigan Medical Bulletin*, April, 1960.

Edward B. Diethrich and **Joe D. Morris, M.D.,** Ann Arbor, "Laboratory Observations on an Extracorporeal Method of Producing Systemic Hypothermia," *University of Michigan Medical Bulletin*, May, 1960.

Peter P. Barlow, M.D., and **Alan I. Bortz, M.D.,** Ann Arbor, "Studies on Repository Antigen Preparations I. Retention of Antigen at the Injection Site in Rats," *University of Michigan Medical Bulletin*, May, 1960.

James H. Maxwell, M.D., Ann Arbor, "Chronic Lymphoepithelial Sialadenopathy With Sialodochiectasis," *Transactions American Academy of Ophthalmology and Otolaryngology*, May-June, 1960.

Merle Lawrence, Ph.D., Ann Arbor, "Acoustic Effects of Middle Ear Substitution," *Transactions American Academy of Ophthalmology and Otolaryngology*, May-June, 1960.

Brian F. McCabe, M.D., Ann Arbor, "Vestibular Suppression in Figure Skaters," *Transactions American Academy of Ophthalmology and Otolaryngology*, May-June, 1960.

William F. Howatt, M.D., David G. Dickinson, M.D., George R. DeMuth, M.D., Gordon C. Brown, Sc.D., and **Donald E. Craig, Ph.D.,** Ann Arbor, "Clinical and Virological Analyses of Nonbacterial Meningo-Encephalitis: A Three-Year Study, *University of Michigan Medical Bulletin*, May, 1960.

K. R. Magee, M.D., I. F. Duff, M.D., W. Martel, M.D., W. M. Mikkelsen, M.D., G. L. Brody, M.D., K. P. Mathews, M.D., and **C. W. Castor,** "Clinicopathological Conference: 'Malignant' Rheumatoid Arthritis," *The University of Michigan Medical Bulletin*, April, 1960.

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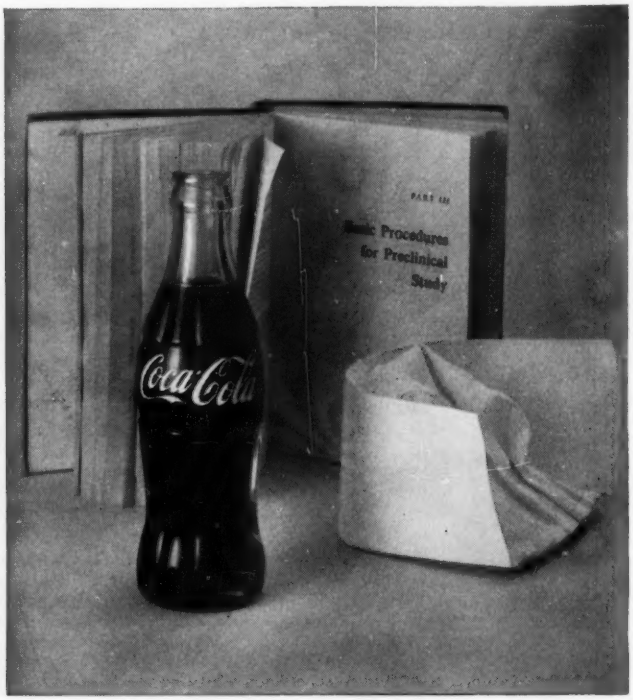
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Richard T. McDonald, M.D., San Diego, California, **Leo Chaikof, M.D.,** and **Joseph P. Truant, Ph.D.,** Detroit, "An Analysis of Prophylactic Measures in Experimental Tetanus," *Surgery, Gynecology and Obstetrics,* June, 1960.

Richard D. Stewart, M.D., and **Roland S. Gohlke, M.S.,** Midland, "The Analysis of Volatile Compounds in Blood by Conventional Mass Spectrometry," *The University of Michigan Medical Bulletin,* April, 1960.

Edward A. Carr, Jr., M.D., William H. Beierwaltes, M.D., and **Norma R. Spafford, A.B.,** Ann Arbor, "The Uptake of Triiodothyronine by Erythrocytes in Pregnancy Complicated by Thyrotoxicosis," *The University of Michigan Medical Bulletin,* April, 1960.

James A. Greene, III, M.D., Ann Arbor, "Spontaneous Paracentesis by Rupture of Umbilical Hernia in a Patient with Cirrhosis," *University of Michigan Medical Bulletin,* May, 1960.

Eugene A. Osius, M.D., Detroit, "Vascular Complications of Pregnancy," *Illinois Medical Journal,* June, 1960.

R. C. Dickenman, M.D., E. G. Krieg, M.D., and **J. D. Lampton, M.D.,** Detroit, "Duplication of the Rectum," *Gastroenterology,* Vol. 38, No. 3, March, 1960.

Harry M. Nelson, M.D., Ester M. Dale, M.D., Gerald S. Wilson, M.D., Detroit, "Methods of Obtaining Cell Material and Evaluation of Results," *Virginia Medical Monthly,* April, 1960.

The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

WOMEN AND FATIGUE. A Woman Doctor's Answer. Marion Hilliard, M.D. Garden City, New York: Doubleday & Company, Inc., 1960. Price $2.95.

This is a short review of the causes and effects of fatigue in women. The author presents the mental as well as the physiological basis of fatigue and its relationship to the various glandular changes found throughout a woman's life. One of the most interesting sections explains the real and practical solutions of fatigue as well as presenting clinical examples derived from the author's medical practice. This book is primarily of value to the layman but makes interesting reading for those of the medical profession.

J. P.

BONE TUMORS. By Louis Lichtenstein, M.D., Chief Pathologist, General Medical and Surgical Hospital, Veterans Administration Center, Los Angeles; Fellow, New York Academy of Medicine; Professor Extraordinario, National University of Mexico; Consultant in Bone Tumors, Tumor Tissue Registry of California Medical Association Cancer Commission; Consultant in Pathology, Los Angeles County Hospital; Consultant, City of Hope Medical Center. Second Edition. 220 illustrations. St. Louis: The C. V. Mosby Company, 1959. Price, $12.00.

The introduction to, and classification of, bone tumors in this book is extensive and thought provoking.

There is a good summary and discussion at the end of the chapter devoted to each tumor with a comparison of the exact value of x-ray and histologic diagnosis with a forthright opinion as to treatment.

The text is well written in an interesting manner and is somewhat reminiscent of the works of Dr. Boyd.

X-ray reproductions are excellent and numerous and exceed by fat the number of photomicrographs. The illustrations will be of interest to physicians in general, as well as to radiologists and orthopedists, and possibly slightly less so to pathologists.

The chapter on non-neoplastic lesions of the bone, which may be erroneously diagnosed as tumors, is particularly current in thought and excellent. This chapter is included in a lengthy and worthwhile appendix that also discusses such related topics, as villonodular synovitis, osteochondromatosis and synovioma. Many times merely a brief mention is made of certain entities and the reader is referred to a well-documented bibliography for further detail, but I doubt if few pertinent subjects are lacking.

A. A. H.

OBSTETRIC EMERGENCIES. Edited by Martin L. Stone, M.D. PEDIATRIC GYNECOLOGY. Edited by John W. Huffman, M.D. New York. Paul B. Hoeber, Inc. Medical Division of Harper & Brothers, 1960.

The first portion of this book deals with Obstetric emergencies. The subjects included are: anaesthesia, failed forceps, transverse presentations, rupture of the uterus.

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Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
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SAMPLES ON REQUEST

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toxemia, abruptio placentae, postpartum hemorrhage, acute renal failure, abdominal emergencies, and cardiac arrest. These subjects are excellently presented. Their brevity and completeness is of great help to those who want a full résumé without too much detail. A complete reference is presented for those who desire more information. The chapter on postpartum hemorrhage is excellent.

The second portion of this book is concerned with Pediatric Gynecology. This is a relatively new subject but one of great importance. It is of value to the pediatrician, gynecologist and the general practitioner. One of the most interesting chapters is on vaginitis. The subject of the intersexed female is very complete and detailed. The authors point out that diagnosis and medical treatment of children is of prime importance especially in constitutional sexual precocity. Too many laparotomies and hysterectomies on children are done which are not necessary. This section would be of great value to all people in the medical field and is excellent as a reference.

J. P.

THE TREATMENT OF BRONCHIAL NEOPLASMS. By Robert R. Shaw, M.D., and Donald L. Paulson, M.D., with a chapter on Bronchial Adenoma by John Lester Kee, Jr., M.D. Springfield, Illinois: Charles C Thomas, 1959. Price, $8.00.

Today, it is extremely refreshing to pick up a book on carcinoma of the lung without delving through many statistics and references, to prove the author's concepts, as to the etiology. Indeed, "The Treatment of Bronchial Neoplasms" by Shaw and Paulson, does not even mention whether the filter on a cigarette is of value or not. Instead, the book is a straightforward presentation of the philosophy of the authors, concerning the rationale of treatment, based upon the theory of biological predeterminism of tumors and upon their experience, with different types of operative procedures, irradiation, and chemotherapy. The book is written entirely from a Surgeon's standpoint. It does not go into the techniques of irradiation but rather gives intelligent indications. It mentions the application of certain chemotherapeutic agents, and points out rather well the fallacy of empirically applying a radical operation to all patients with cancer. The book is small, readable, and gives an approach to the problem of cancer of the lung, which may be challenged by some people as being conservative, but yet does not do a disservice to the patient.

This publication is one of the John Alexander Monograph Series, which is written by his former residents, with the unselfish desire to perpetuate the discipline and high standards of their mentor. As with the other books in the series, it does not really come under the category as a monograph, because it is not all inclusive in its bibliography and coverage of the subject matter. Nevertheless, Surgeons and Physicians, dealing with this dread disease, will find the information and therapeutic philosophy extremely valuable.

E. J. K.

DIABETES WITH A CHAPTER ON HYPOGLYCEMIA. By 54 authors. Edited by Robert H. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington; Physician-in-Chief, University Hospital, Seattle. 771 pages, 192 illustrations. 23 in full color. New York: Paul B. Hoeber, Inc. Medical Division of Harper & Brothers, 1960. Price, $20.00.

This edited volume with its adequate index is the finest one-volume work on diabetes and hypoglycemia ever read by the reviewer. It covers the field of diabetes completely. It is interestingly and simply written with many excellent illustrations. The chapter on diet is especially well done with attention given to the latest theories of diet control, such as saturated versus unsaturated fats.

Oral drugs in the treatment of diabetes are allotted 35 pages; the subject is well covered. Hypoglycemia is interestingly and comprehensively covered as are the many complications of diabetes.

This is an especially fine volume which any physician, who comes in contact with diabetes in his practice, should have in his library.

L. P. S.

FIRST AID DIAGNOSIS AND MANAGEMENT. By Warren H. Cole, Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Surgeon-in-Chief, Research and Educational Hospitals, Chicago, and Charles B. Puestow, Clinical Professor of Surgery, University of Illinois College of Medicine and Graduate School; Chief, Surgical Service, Veterans Administration Hospital, Hines; Attending Surgeon, Research and Educational Hospitals; Senior Surgeon, Henrotin Hospital; Associate Surgeon, Presbyterian-St. Luke's Hospital, Chicago; Colonel, M.C., A.U.S., with 16 Contributing Authors. New York: Appleton-Century-Crofts, Inc. 1960. Price, $6.25.

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H.A.

COMMUNICABLE AND INFECTIOUS DISEASES. Diagnosis, Prevention, Treatment. By Franklin H. Top, A.B., M.D., M.P.H., F.A.C.P., F.A.A.P., F.A.P.H.A., Professor and Head, Department of Hygiene and Preventive Medicine, State University of Iowa, Iowa City, Iowa; Director, University Department of Health, and Director, Institute of Agricultural Medicine, State University of Iowa; Consulting Director, State (of Iowa) Hygienic Laboratories; Consultant in Infectious Diseases, University Hospital, Iowa City, Iowa; Consultant Communicable Disease Center, U. S. Public Health Service, Atlanta Georgia; formerly Professor of Epidemiology, School of Public Health, and Professor of Pediatrics, College of Medical Sciences, University of Minnesota, Minneapolis, Minn.; formerly Clinical Professor of Preventive Medicine and Public Health, Wayne State University College of Medicine, Detroit, Mich.; formerly Director, Herman Kiefer Hospital, Detroit, Mich., and Collaborators. Fourth Edition. 122 figures and 15 color plates. St. Louis: The C. V. Mosby Company, 1960. Price, $20.00.

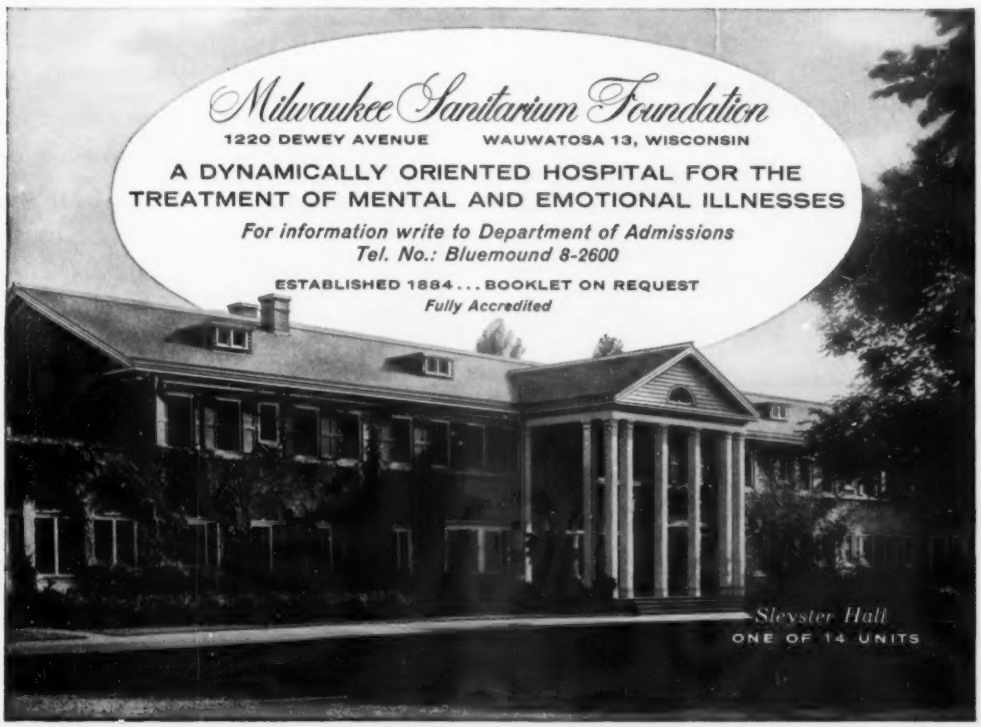
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F. J. M.

HOSPITAL UTILIZATION UNDER INSURANCE. Monograph No. 6. By Milton I. Roemer, M.D., and Max Shain, American Hospital Association, 840 North Lake Shore Drive, Chicago 11, Illinois, $1.75.

CIBA FOUNDATION SYMPOSIUM ON THE BIOSYNTHESIS OF TERPENES AND STEROLS. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Maeve O'Connor, B.A. 102 illustrations. Boston: Little, Brown and Company, 1959. Price, $8.75.



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Borden's 1281
Brighton Hospital 1291
Bristol Laboratories 1181, 1271
Burroughs Wellcome & Co. 1268

Central Laboratory 1294
Central Pharmacal Co. 1275
Ciba 1171
Classified Advertising 1298
Coca-Cola 1294
Columbus Pharmacal Co. 1178

Durst, S. F., & Co., Inc. 1293

Geigy 1279

Hack Shoe Co. 1280
Health-Mor, Inc. 1154, 1155

Ingram, G. A. Co. 1180, 1288

Keeley Institute 1296

Lederle Laboratories 1180, 1226-B, 1226-C, 1274, 1289, 1292
Lilly, Eli & Co. 1190
Loma Linda Food Co. 1300

Medical Arts Supply Co. 1274
Medical Protective Co. 1290
Merck, Sharp & Dohme 1150, 1187
Mercywood Sanitarium 1299
Meyer & Co. 1289
Milwaukee Sanitarium Foundation 1297

Noble-Blackmer, Inc. 1272

Parke, Davis & Co. ..... Cover II, 1149
Pharmaceutical Manufacturers Association 1283
Physicians Casualty & Health Association 1292
Plainwell Sanitarium 1298
Professional Management 1299

Robins, A. H., Co. 1165, 1173
Roerig 1163

Sammond Pleasant Lodge 1164
Sanborn Co. 1156
Saunders, W. B., Co. 1167
Searle 1267
Smith, Kline & French Laboratories ..... Cover IV
Squibb 1182, 1226-A

Testagar & Co. 1185
Tutag, S. J., & Co. 1295

U. S. Savings Bonds 1169
U. S. Vitamin & Pharmaceutical Corp. 1286, 1287

Wallace Laboratories ..... 1153, 1174, Insert (1175, 1176), 1177, 1188, 1189
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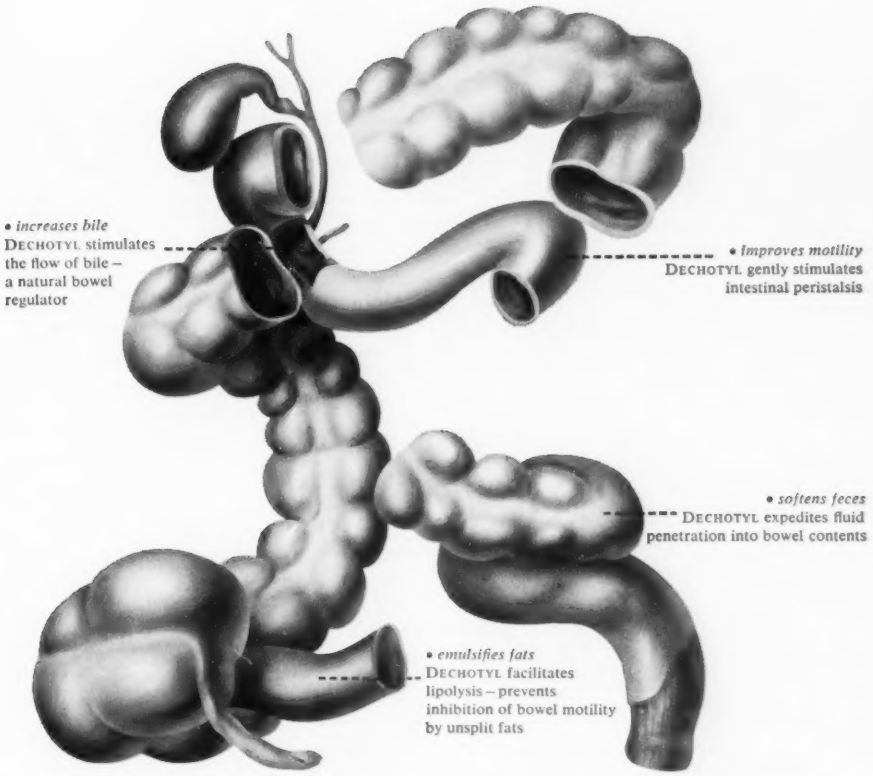
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